

JOURNAL



OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION

JANUARY

2000

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Managing Editor: Karen A. Evers
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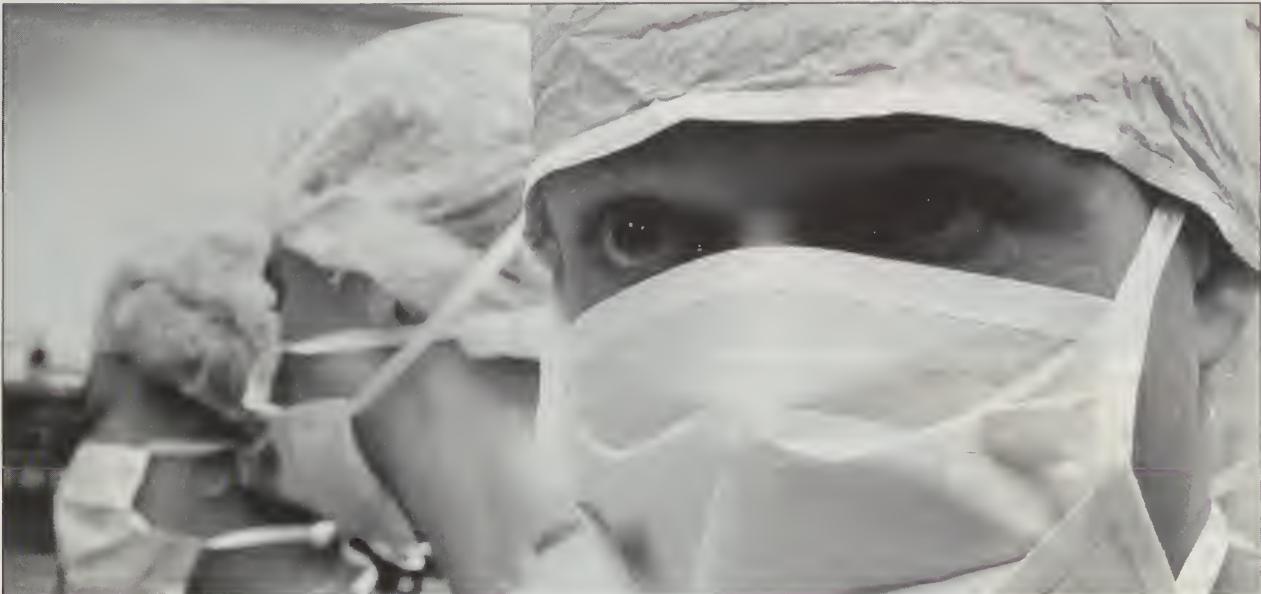
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Referral Patterns of Physicians Requesting Brain MRI Procedures: A Community-Based Study

A. S. Wee, M.D.
M. A. Cowart, M.D.
P. D. Mosley

A BSTRACT

The results of the brain MRI procedures (n=490) performed in a medium-sized community with a single MRI unit were reviewed. The non-neurologic medical practitioners ordered nearly as many brain scans as the neurospecialists (40.8% and 59.2% of the total scans respectively). The incidence of abnormal scans was 29.5% for the group of non-neurospecialists and 39.3% for the neurospecialists. A fairly large proportion (26.7%; n=131) of the scans were requested to evaluate headaches. Twelve patients (9.2%) with headaches but without clear neurologic localizing features showed intracranial abnormalities in their MRI scans. Some of the abnormalities observed in the brain MRI scans could have been detected by a CT procedure.

Key Words: Magnetic resonance imaging;
computerized axial tomography;
brain scans.

INTRODUCTION

Magnetic resonance imaging (MRI) is a computer-aided diagnostic procedure similar in some respects to x-ray computed tomography (CT). Unlike CT, however, MRI does not utilize ionizing radiation to image human structures. Instead, MRI processes signals that are the results of the interaction between hydrogen nuclei (protons) in tissues and externally applied radio waves in the presence of a strong magnetic field. A fairly safe procedure, it is generally agreed that MRI is superior to CT in terms of imaging the central nervous system. MRI gives greater detail in the brain anatomy with good distinction

between gray and white matter. This can be accomplished with thin cross-sectional images obtained in multiple planes and orientations. There are no bone artifacts, and the brainstem and posterior fossa structures can be visualized with great clarity. MRI is very sensitive to increased water content in tissues permitting early detection of edema resulting from an inflammatory or a neoplastic process. Despite the advantages over CT, MRI is relatively more expensive and is not readily available in small community hospitals. With rising health-care costs and in the current atmosphere of managed care, MRI is usually not performed on a routine basis.

The request for a brain MRI study is not limited solely to physicians in the different neurologic specialties. The procedure is accessible to any licensed medical practitioner including those involved in primary care medicine. Given the broad experience that a neurospecialist may have in dealing with neurologic diseases, it would seem logical to assume that a brain scan ordered by a neurospecialist will more than likely reveal a pathology when compared to a scan requested by a non-neurologic practitioner. To determine if any difference could be observed between these two sets of brain MRI scans, a study was conducted prospectively in a community that is subserved by a single MRI scanner.

METHODS AND MATERIALS

The study was conducted in Meridian, a city with a population of 41,000 in Lauderdale County, Missis-

sippi. This community has three medium-sized hospitals (180-260 beds) which provide medical care to the residents and as well as to a drawing patient population of approximately 150,000 from adjacent regions. A single General Electric MRI scanner with a magnetic-field strength of 1.5 tesla provides the diagnostic imaging service to all three hospitals and surrounding areas. Lauderdale County has more than 150 practicing physicians listed in the directory of the Mississippi State Medical Association. At the time of the study, Meridian had four full-time neurologists and two full-time neurosurgeons.

Between May and December 1996, all brain MRI results were prospectively reviewed and examined. The name and medical specialty of the health-care provider who requested the scan and the patient's pertinent clinical information were recorded. The brain MRI scans were obtained initially without contrast and then with contrast (gadolinium), unless the latter was contraindicated. T-2 weighted, T-1 weighted, and intermediate-weighted (proton-density) scans were obtained in all patients. The brain scans were classified as either normal (negative) with no significant intracranial pathology or abnormal (positive). Small areas of increased signals noted in the brain white matter in the T-2 weighted images alone were not considered abnormal, particularly in the elderly. White matter disease was considered if the abnormalities were present not only in the T-2 weighted scans but also in the T-1 weighted or proton-density scans.

RESULTS

Of the 490 brain MRI procedures performed, 290 (59.2%) were ordered by neurospecialists and 200 (40.8%) by the remaining medical practitioners. Of the 490 scans, 173 (35.3%) were positive and showed intracranial abnormalities, and 317 (64.7%) scans were negative.

Of the 290 brain MRI scans ordered by the neurologists and neurosurgeons, 114 (39.3%) were positive scans and 176 (60.7%) were negative. Among the four full-time neurologists, the number of scans ordered ranged between 53 and 92; the incidence of positive scans relative to the amount of scans ordered ranged between 21.9% and 56.6%. There were two scans ordered by an out-of-town neurologist, both of which were positive. The two full-time neurosurgeons ordered 24 scans, and two out-of-town neurosurgeons ordered a scan each for a total of 26 scans. Of the 26 scans requested by the neurosurgeons, 23 (88.5%) were positive and 3 (11.5%) were negative.

Among the non-neurospecialists, of the 200 brain MRI scans requested, 59 (29.5%) were positive and 141 (70.5%) were negative.

Of the total 490 brain MRI scans, 131 (26.7%) were requested to evaluate headache or this symptom was listed as one of the major complaints by the patient or referring physician. Of the 131 scans, 25 (19.1%) were positive and 106 (80.9%) were negative. The patient profiles in the 25 positive scans were as follows: 5 patients had previous craniotomy procedures for brain tumors, 8 had headaches with accompanying focal neurologic signs or symptoms, and 12 had headaches without clear neurologic localizing abnormality. Table I lists the specific abnormalities noted in the brain scans of 12 patients with headaches but without definite localizing neurologic features.

Table I.— Brain MRI findings in 12 patients with headaches and no definite localizing neurologic features.

1. Empty sella.
2. Small choroid fissure cyst.
3. Small pituitary adenoma.
4. Empty sella.
5. Venous angioma vs. arteriovenous malformation (AVM).
6. Small right occipital AVM.
7. Small left occipital AVM.
8. Left cerebellar hematoma.
9. Bilateral chronic subdural hematomas.
10. Right temporo-parietal infarct.
11. Multiple brain abscesses.
12. Left parietal mass lesion.

DISCUSSION

This study reveals that non-neurologic medical practitioners ordered nearly as many brain MRI procedures as neurospecialists (40.8% and 59.2% of the total number of scans ordered respectively). It is interesting to note that there is not a wide discrepancy in the incidence of abnormal scans requested by non-neurospecialists as opposed to neurospecialists (29.5% vs. 39.3%). This finding seems to indicate that the non-neurologic practitioners have shown some restraint when ordering a brain MRI procedure and that this study is not performed on a routine or regular basis. This is compared to the retrospective study of brain MRI scans performed on 1000 normal volunteers at the National Institutes of Health which showed that 82% of the scans were normal and 18% had incidental abnormal findings.¹ Of those with abnormal scans, a majority (n=132) of the volunteers had

extracranial pathologies consisting of paranasal sinusitis.

Among the neurospecialists, there appears to be a great discrepancy in the incidence of abnormal brain MRI scans requested. In the group of neurologists, this ranged from 21.9% to 56.6%. The neurosurgeons seem to have the highest incidence of positive (abnormal) scans ordered (88.5%). However, they ordered the least number of brain MRI scans (26 or 5.3% of total). This could be explained by the fact that most patients referred to neurosurgery may already have had a CT or MRI scan.

A fairly large proportion of brain MRI procedures (131 or 26.7% of total) were requested for the evaluation of headaches. Twelve patients (9.2% of 131) who had headaches but without definite localizing neurologic features showed intracranial abnormalities in their brain MRI scans. Of the abnormalities noted, five could have been easily detected by a CT procedure (bottom 5 abnormalities listed in Table I). This leaves seven patients (5.3%) with intracranial abnormalities in whom an MRI procedure may have provided additional information (top 7 abnormalities listed in Table I). The size, nature, and location of the intracranial pathologies in these patients may not have allowed a CT procedure to define these lesions with greater precision when compared with MRI.

It appears that in the MRI evaluation of patients with headaches but without focal neurologic signs or symptoms, a relatively small percentage of the brain scans will show intracranial abnormalities while a proportion of these could have been detected by a CT procedure.

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Dr. Wee is an Associate Professor of Neurology at the University of Mississippi Medical Center, Jackson, MS.

Dr. Cowart is in private practice in Radiology in Meridian, MS.

Ms. Mosley is a registered MRI Technologist in Meridian, MS.

Address correspondence and reprint requests to:

A. S. Wee, M.D.
Department of Neurology
University of Mississippi Medical Center
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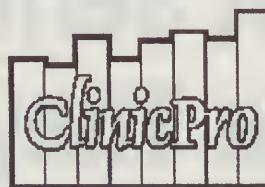
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Twenty Year Primary Care Graduate Survey at the University of Mississippi Medical Center

Robert C. Forbes, M.D.¹
John C. Morrison, M.D.²
D. Melessa Phillips, M.D.¹
William H. Replogle, PhD.¹

The Department of Family Medicine at the University of Mississippi Medical Center graduated its first residents in 1976 after a three-year training period. A graduate survey done in 1989 was published in 1992 which showed 80 percent of our graduates to be practicing in Mississippi and relatively happy with their training.¹

With the emphasis on primary care over the past decade, we decided to repeat the process combining with the other primary care departments at our institution - Pediatrics, Internal Medicine and Obstetrics & Gynecology. We asked graduates about their practice characteristics and their opinion of the training they received. Accreditation bodies, in particular Residency Review Committees, require continuing contact with graduates to evaluate training.

A 1997 study showed that, of all patient visits to a physician's office, 61.6% were to a primary care physician. A Family Physician saw 25.5%, a General Internist 15.4%, a Pediatrician 11.7% and an Obstetrician-Gynecologist 9.0%.²

The Resident Review Committee in Obstetrics and Gynecology requires a major emphasis on primary care. In a recent review article among graduates of our Ob-Gyn program³, 93% of the respondents said that they routinely treated primary care patients in their practice.

METHODS AND MATERIALS

We designed a survey to elicit information regarding the graduates' practice location, speciality, setting, and board certification. The graduates also rated on a 10-point scale their satisfaction with their career choice, the extent to which their residency prepared them for practice, and the relevancy of residency training to practice. A "1" indicated very satisfied and a "10" indicated very dissatisfied. We surveyed all graduates with a known address (1976 through 1995, inclusive) of the departments of Family Medicine (n=204), Internal Medicine (n=307), Obstetrics and Gynecology (n=101), and Pediatrics (n=141) of the University of Mississippi Medical Center.

RESULTS

Forty-seven percent (354) of the 753 graduates returned usable surveys. The response rates for the departments of Family Medicine, Internal Medicine, Obstetrics and Gynecology, and Pediatrics were 40 percent, 38 percent, 73 percent, and 57 percent, respectively.

As noted in Table 1, greater than 98 percent of the primary care residency graduates are currently practicing medicine and, 95 percent of the graduates are board certified. Additionally, nearly 70 percent of the gradu-

Table 1*

	Family Medicine	Internal Medicine	Obstetrics/ Gynecology	Pediatrics	Total
Respondents	82	118	74	80	354
Currently Practice Medicine	82 (100)	116 (98.3)	72 (97.3)	78 (97.5)	348 (98.3)
Board Certified	81 (98.8)	116 (98.3)	67 (90.5)	74 (92.5)	338 (95.5)
Resident of Mississippi	68 (82.9)	89 (75.4)	38 (51.4)	51 (63.8)	246 (69.5)
Practice Type:					
Solo	19 (23.2)	11 (9.3)	6 (8.1)	5 (6.3)	41 (11.6)
Group (single specialty)	41 (50.0)	52 (44.1)	53 (71.6)	38 (47.5)	184 (52)
Group (multi specialty)	16 (19.5)	45 (38.1)	14 (18.9)	31 (38.8)	106 (30)
No response	6 (7.3)	10 (8.5)	1 (1.4)	6 (7.5)	23 (6.5)
Employer:					
Hospital/corporation	19 (23.2)	30 (25.4)	11 (14.9)	26 (32.5)	86 (24.3)
HMO	0 (0)	1 (.9)	2 (2.7)	3 (3.8)	6 (1.7)
Military	0 (0)	1 (.9)	1 (1.4)	0 (0)	2 (.6)
Community health center	4 (4.9)	0 (0)	0 (0)	1 (1.3)	5 (1.4)
Self	37 (45.1)	48 (40.7)	49 (66.2)	30 (37.5)	164 (46.3)
Other	16 (19.5)	24 (20.3)	9 (12.2)	11 (13.8)	60 (17)
No response	6 (7.3)	14 (11.9)	2 (2.7)	9 (11.3)	31 (8.8)
Practice Setting:					
Private office	53 (64.6)	82 (69.5)	60 (81.1)	50 (62.5)	245 (69.2)
Emergency department	5 (6.1)	6 (5.1)	0 (0)	4 (5)	15 (4.2)
Urgent care clinic	4 (4.9)	1 (.9)	0 (0)	0 (0)	5 (1.4)
Community/public health	5 (6.1)	3 (2.6)	0 (0)	4 (5)	12 (3.4)
Academics/medical school	9 (11)	14 (11.9)	11 (14.9)	17 (21.3)	51 (14.4)
Others	3 (3.7)	8 (6.8)	1 (1.4)	3 (3.8)	15 (4.2)
No response	3 (3.7)	4 (3.4)	2 (2.7)	2 (2.5)	11 (3.1)

* N (%)

ates practice in Mississippi. For each of the specialities, a single speciality group practice was the most common practice arrangement. The second most common practice arrangement was a solo practice for Family Physicians and a group multi-speciality practice for the other three specialities. For each of the specialities, the most common employment situation was self-employment and the most common practice setting was a private office followed by academic health centers. General family practice, obstetrics and gynecology, and pediatrics were reported to be the primary area of practice for 89.0 percent, 74.3 percent, and 67.5 percent of the family medicine, obstetrics and gynecology, and pediatrics graduates, respectively. (Table 2) Thirty-seven percent of the internal medicine graduates reported that general internal medicine was their primary area of practice while the remaining 63 percent reported that a sub-speciality was the primary area of practice.

The graduates appeared to be satisfied with their career choice (mean=2.3, S.D.=1.8), the extent to which their residency prepared them for practice (mean=2.4, S.D.=1.6), and the relevancy of their residency training (mean=2.3, S.D.=1.6).

Discussion

These data show that for the most part our graduates continue to practice in the area of primary care in which they were trained. This is particularly true for Family Medicine, Obstetrics/Gynecology, and Pediatrics where nearly 90%, 75%, and 67%, respectively, reported primary care as their area of emphasis. Internal medicine had a little over 1/3 involved in the general practice of medicine. This is important because as a rural state, physicians particularly far from large cities need to be skilled in all areas of primary care rather than in discrete small subspe-

Table 2 *

FAMILY MEDICINE	INTERNAL MEDICINE	OBSTETRICS/ GYNECOLOGY	PEDIATRICS
Respondants 82	Respondants 118	Respondants 74	Respondants 80
Family Medicine 73 (89)	Internal Medicine 44 (37.3)	Obst./Gyn. 55 (74.3)	Pediatrics 54(67.5)
Emergency Room 3 (3.7)	Pulmonary 13 (11)	Gyn./Onc. 4 (5.4)	Allergy 4 (5.0)
Other 3 (3.7)	Cardiology 11 (9.3)	Gynecology 4 (5.4)	Neonatology 4 (5.0)
No Response 3 (3.7)	Gastrointestinal 9 (7.6)	Repro./Endo. 3 (4.1)	Emergency Room 2 (2.5)
	Emergency Room 6 (5.1)	Other 2 (2.7)	Endocrinology 2 (2.5)
	Infectious Disease 5 (4.2)	No Response 4 (5.4)	Pulmonary 2 (2.5)
	Oncology 5 (4.2)		Cardiology 2 (2.5)
	Rheumatology 3 (2.6)		Other 5 (6.3)
	Nephrology 2 (1.7)		No Response 5 (6.3)
	Radiology 2 (1.7)		
	Anesthesia 1(<1)		
	Allergy 1(<1)		
	EP 1(<1)		
	Geriatrics 1(<1)		
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	College Health 1(<1)		
	Pathology 1(<1)		
	Neurology 1(<1)		
	Psychiatry 1(<1)		
	Hypertension 1(<1)		
	Nuclear Cardiology 1(<1)		
	No Response 5 (4.2)		

* N (%)

cialty areas. As emphasized by other articles, graduates of a medicine program are the least likely to practice general medicine and this was true in our study. This is offset by the fact that internal medicine has the largest number of graduates; therefore, the number of physicians practicing general internal medicine was equal to the other three groups numerically.

On the whole these data show that the training which residents in primary care programs at UMC receive is relevant to their practice in our rural state. It is also positive that 98% of the graduates are still practicing medicine and that the majority in family medicine, obstetrics, and pediatrics are practicing in a primary care area. We must be vigilant in several areas, however. First, the decision on what constitutes "good training" is frequently made by resident review committees, and the views of rural states as to what is germane in the training program may not be evident. Our input is vital to these organizations and we should make an effort, as we have in the past, to make certain that they hear our voice. Secondly, we need to make certain that managed care as well as changes in the federal government such as HICFA, the anti-stark

provisions, the balanced budget act among others don't negate our efforts to keep primary care specialties alive and well for all Mississippians.

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Robert C. Forbes, M.D., D. Melessa Phillips, M.D. and William H. Replogle, PhD. practice with the Department of Family Medicine, University of Mississippi Medical Center. **John C. Morrison, M.D.** is in the Department of Obstetrics and Gynecology, University of Mississippi Medical Center.

Hospice in Mississippi: An Update

Karen A. Evers
Managing Editor

INTRODUCTION

With concern over physician-assisted suicide and other end-of-life issues escalating, a recent study in the *Journal of the American Medical Association (JAMA)* reported that most Americans could not use hospice care because current Medicare regulations require that patients be expected to die within 6 months or less—and, based on critical criteria doctors can only give a professional estimate on who will live or die within a 6 month period. Yet, if you talk to people who have experienced hospice care, volunteered or provided care or had any encounter with hospice organizations most have nothing but positive things to say.

Some are even passionate in telling you how wonderful the program is. They remark how meaningful hospice was to their family and loved one which seems to contrast with the concept of grief associated with death. These testimonials confirm the acceptance of helping the patient approach death with palliative medical care, living to the end in love and comfort. This special article is an attempt to update an article, "Hospice Care in Mississippi," that appeared in the September 1996 issue of the *Journal of the Mississippi State Medical Association (JOURNAL MSMA)* and provide information physicians may find of assistance.

Background

A great deal evolved from the concept of hospice in ancient times when small inns were located in the Alps of Europe, usually with some religious orders, welcoming weary travelers and providing shelter to the sick or poor to the June 1996 *JOURNAL MSMA* article entitled "Issue at the End of Life is Quality of Care" which identified the need for legislation ensuring access to

hospice benefits. The article quoted a testimony given by, then president of the AMA, Lonnie R. Bristow that noted the entire concept of hospice is now being recognized in the United States as part of the continuum of health care. And, much has changed since then.

Then, the Mississippi Hospice Organization (MHO) reported "hospice care in the home has grown from 5 to 26 members covering most of the state." Today, the Mississippi State Department of Health Division of Health (MSDH) Facilities Licensure & Certification reports 40 hospice licensed and certified for participation in the Medicare and/or Medicaid Programs in the state.

Medicare hospice participation continues to grow at a dramatic rate. According to the National Hospice Organization (NHO), in 1998, 80% of hospices were Medicare certified, 5% were not certified, and 15% were unidentified. In 1998, 57% of hospices were Medicaid certified, 1% were not certified, and 42% were unidentified. As of 1999, hospice is covered under Medicaid in 43 states plus the District of Columbia.

A 1995 national study by Lewin-VHI commissioned by NHO showed that for every dollar Medicare spent on hospice, it saved \$1.52 in Medicare Part A and Part B expenditures. A 1988 study conducted by HCFA (Health Care Financing Administration) showed savings of \$1.26 for every Medicare dollar spent on hospice. Thus, hospice cost savings have actually increased in recent years. The 1995 study also showed that in the last year of life, hospice patients incurred \$2,737 less in costs than those not on the Medicare Hospice Benefit. These savings totaled \$3,192 in the last month of life, as hospice home care days often substituted for expensive hospitalizations.

Three years ago in Mississippi inpatient hospice

American Medical Association Policy and Advocacy

H-85.963 Medicare Hospice Benefit

Our AMA will seek amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure. (Res. 101, A-99)

H-85.966 Hospice Coverage and Underutilization

The policy of the AMA is that: (1) The use of hospice care be actively utilized to provide the patient and family with appropriate physical and emotional support, but not preclude or prevent the use of appropriate palliative therapies to continue to treat the underlying malignant disease, if the patient is showing response to such palliative therapy; (2) The goal of terminal care is to relieve patient suffering and not necessarily to cure incurable disease; (3) Appropriate active palliation should be a covered hospital benefit; and (4) The initiation of hospice care may be done at the discretion of the attending physician without stopping whatever medical care is being rendered if the physician believes the patient is in the last six months of life. (Res. 515, A-94)

H-85.972 The Compassionate Care of the Terminally Ill

The AMA will work with appropriate entities to promote the awareness of modern high-quality hospice-type care to all those who prefer such care and urges physicians to advise patients about this option, which can be exercised directly, when competent, or via advance directive when incompetent. (Res. 705, A-92)

H-85.991 Hospice Program Regulations for Medicare Qualification

The AMA supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare. (Res. 174, A-84; Reaffirmed by CLRPD Rep. 3 - I-94)

H-85.994 Hospice Standards

The AMA believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program. (Sub. Res. 46, A-83; Reaffirmed: CLRPD Rep. I-93-1)

H-85.997 Hospice Programs

The AMA strongly supports continuation of studies by private and public third parties in paying for hospice care, with the goal of designing coverage for medical charges and costs incurred by individuals electing to remain at home for the period of treatment required in the case of terminal illness, thereby encouraging alternative, less costly treatment settings. (Sub. Res. 40, I-80; Reaffirmed: CLRPD Rep. B, I-90)

H-85.999 Hospices

The AMA (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and (2) urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care. (Sub. Res 82, A-78; Reaffirmed: CLRPD Rep. C, A-89)

H-140.949 Physician-Assisted Suicide

The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life. (BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99)

care was provided by a few leased beds in skilled nursing homes and hospitals, but Whispering Pines Hospice was the only facility dedicated specifically to inpatient care. Today, there are three inpatient facilities, Hospice Ministries, Inc. (a merger of Whispering Pines and Hospice of Central Mississippi), Heartfelt Hospice in Meridian and SouthernCare Hospice of Brookhaven, all offering inpatient care.

Whispering Pines

Whispering Pines was the forerunner in residential facilities for this area. Certified on January 1, 1991, it opened in a former nursing home on Raymond Road in Jackson with 10 beds and slowly grew to 36 as of April, 1995. Dr. William A. Causey has been Medical Director of Whispering Pines since its inception.

Whispering Pines was founded in January of 1989 by the Bishops of the Roman Catholic, Episcopal, and United Methodist Churches in Mississippi who recognized the growing need for an inpatient hospice to care for the terminally ill who either had no care giver or perhaps no home. Three bishops, with a community-based board, organized the Ecumenical Health Care Organization (EHCO) as the first step to address that need.

Hospice of Central Mississippi

In the Fall of 1988 a small group of people began to research the possibility of providing in-home hospice for the greater Jackson metropolitan area. Having hospice care for her terminally ill patients was a long-time dream of Dr. Gerry Ann Houston, a local oncologist in private practice with Jackson Oncology Associates. This dream was shared by Dan Broughton, a charitable businessman in the health care industry who wanted to give something back to the community. Together, with the help of many other supporters, they organized Hospice of Central Mississippi (HOCM).

The first patient was admitted in April of 1989 and at the time it was the only hospice in the central Mississippi region to provide in-home care. Hospice Ministries has served more than 4,000 patients in 25 counties and parishes in Mississippi and Louisiana since it first opened and expanded its service with offices in Brookhaven, Forest, Vicksburg and Natchez.

Hospice Ministries, Inc.

In 1997, Whispering Pines and Hospice of Central Mississippi merged for continuum of care to form Hospice Ministries, Inc. Rondah Marks, marketing-development director for Hospice Ministries, Inc. said, "The merger represents the combination of two ministries with



Dr. William A. (Bill) Causey is a specialist in Infectious Disease and Internal Medicine with the Jackson Medical Clinic. A graduate of the University of Mississippi Medical Center, he is certified by the American Board of Internal Medicine and is a member of the Association for Practitioners in Infection Control. Dr. Causey was a Research Medical Officer with the Centers for Disease Control and is currently Clinical Associate Professor of Medicine at the University of Mississippi Medical Center. He is a member of the Hospice Ministries' Board of Directors.

the common mission of contributing to the quality of life of terminally ill patients and their families."

A state-of-the-art facility on Towne Center Boulevard in Ridgeland is the new home for the statewide hospice program. The facility includes five suites containing 50 private rooms for inpatients, a central nurses station allowing medical professionals to respond to patient needs at any time, a prayer room, kitchen and dining facilities, and large day room providing patients and their families a place to gather in a home-like setting, as well as the administrative offices for both in-home and inpatient divisions. Phase II, for the future, includes a chapel and sixth living suite. The building shells for these services are complete.

"The Board's decision to move was based upon a commitment to our ministry- to continue serving the hospice community by assuring the highest quality of care to those facing end of life issues," Marks said.

"David Harris, of Harris Constructors and president of the Ridgeland Chamber of Commerce, has volunteered to coordinate the completion of the chapel as part of a community project. Employees of Harris Constructors as well as other Ridgeland Chamber businesses will donate their time and resources to complete the chapel for the community," she said.

Hospice Ministries, Inc. Inpatient Care

Patients who elect inpatient care receive support from an interdisciplinary team of professionals: nurses, nurses' aides, social workers, chaplains, and volunteers. Though patients may elect to be followed by their own physician their plan of care is overseen by Inpatient Medical Director William A. Causey, M.D. He makes rounds and oversees the care of all patients. Causey said with the exception of one or two he has seen most all of the inpatients. However, if a physician wishes to follow his/her patient they may.

"I think physicians are reluctant to talk with their patients about dying," Dr. Causey said. "And that is one of the leading factors why they don't refer them to us. They don't talk about hospice care because if they talk about hospice care they have to talk about dying and physicians just don't like to do that."

"A lot of doctors are uneducated to what hospice care is about. They have a concept of hospice care being administered more or less like last rites," he said. "I think they need to see it as an opportunity to allow their patients to live life, for as long as life lasts. Hospice neither hastens death or prolongs life. We think of it not as a life-limiting process but a life enriching process for however long a patient has."

Dr. Causey added, "And, that is really what the heart of hospice is, when you take the patient in and the people that are most important to that patient, whether it be a life-mate, wife, husband, children or whoever it happens to be ...the people most important with in the circle closest to that patient... and you treat them as a unit. You incorporate them all into the process. And that includes the educational process about the dying process, about what happens when people die."

"You have to tell them what we know about the things that cause people discomfort and the things that we know don't cause people discomfort. People think you simply have to be fed when we know that terminal dehydration through withholding fluids is not inhumane. When people are actively dying they many times request not to be fed. It does not cause an increase in a patient's discomfort. It is a perfectly reasonable option not to give out any fluids, not to force feed them fluids. To allow a person to die with dignity without doing anything to prolong their illness is far from cruel with different factors in many ways for people with an irreversible terminal illness. But, people have to be educated in these matters and there is no better place to do that than in a hospice setting," Dr. Causey said.

"In hospice care what we focus on rather than diminutive therapy of their underlying disease is symp-

tom management. And the predominant symptoms that we deal with are pain, nausea, anxiety and shortness of breath. We have effective means for managing all of those in a very humane fashion," he said.

"At the same time we are managing those symptoms we are doing the best we can to deal with the other issues the patient has, whether they are spiritual issues surrounding the dying process or whether they are psychosocial issues dealing with abandonment, loneliness ...personal conflicts with family members...whatever things that need to be resolved before a person can die a comfortable death. We try to address all of those issues in the hospice setting."

"Hospice care is intended to be given in the home or in an individual's setting. In my opinion, that would be the desirable place for a person to die. But, there are circumstances in which the bed from home is not possible or not in the best interest. If that's the case, whether it's because they lack a caregiver or if it is a patient or family's preference, then that is what inpatient hospice is for," Dr. Causey explained.

Dr. Causey has been involved in inpatient hospice since the (Whispering Pines) organization started. "I've cared for over a thousand patients with a variety of terminal illnesses and I think for the most part we have been able to achieve our goals of comfort care and effective living for a dying patient. We call it hospice programs because we maintain an aftercare program for the family with grief management for a period of time after a patient dies and I would say it has been a very rewarding nine years," he said.

Hospice Ministries, Inc. In-Home Care

In-home care is provided by the in-home division of Hospice Ministries to those who wish to remain in the familiar surroundings and warmth of home. In order to qualify for in-home services, a patient must be diagnosed and referred by a physician as having a terminal illness and appropriate for hospice care. They must have a caregiver. They also must reside in the Hospice Ministries, Inc. service area which includes Adams, Amite, Claiborne, Copiah, Covington, Franklin, Hinds, Issaquena, Jasper, Jefferson, Jefferson Davis, Lawrence, Leake, Lincoln, Madison, Neshoba, Newton, Pike, Rankin, Scott, Simpson, Smith, Walthall, Warren, and Wilkinson counties in Mississippi and Concordia and Catahoula parishes in Louisiana.

In most cases a patient's private physician continues to follow them and is overseen by a Hospice Ministries In-home Medical Director. Ray A. Montalvo, Jr., M.D., an internist in private practice in Brookhaven, is



Gerry Ann Houston, M.D., is the Medical Director for the Forest, Jackson, and Vicksburg offices of Hospice Ministries, Inc. In-home Division. She is a certified Medical Oncologist and Hematologist in private practice with Jackson Oncology Associates. A graduate of the University of Mississippi Medical Center, Dr. Houston is board certified by the American Board of Internal Medicine and the American Board of Hospice and Palliative Medicine. She is a member of the Hospice Ministries' Board of Directors and is the President of the Professional Advisory Board for Hospice Ministries in-home division. She is also a member of the American Academy of Hospice and Palliative Medicine (AAHPM), an organization in the United States for physicians dedicated to the advancement of hospice/palliative medicine, its practice, research and education.

the Medical Director for that office. Kenneth Stubbs, M.D., internist, is the medical director for the Natchez office and Gerry Ann Houston, M.D., an oncologist and hematologist with Jackson Oncology Associates is the Medical Director for the Forest, Jackson, and Vicksburg offices.

Dr. Houston agrees with Dr. Causey. "I think many times physicians are afraid themselves to acknowledge

that a patient is dying because that means they have failed in taking care of the patient. To me there is a great service you can offer these patients and their families just by taking care of them during their terminal illness. You can be there for other things like emotional support, their family's support, providing anything they need to keep them comfortable, managing their symptoms and taking care of their pain."

Dr. Houston said another problem that occurs quite often is physicians don't refer early enough. "Many wait for families to ask us about hospice," she said. "They don't realize that the family has just as much trouble dealing with the illness as the patient, sometimes more. Hospice is just as much for the families as it is for patients."

"If you look at the different things that Medicare provides hospice versus Medicare Home Health it covers their medications, any piece of equipment that they need, supplies and those are costly things that the patient might have to pay for if they had home health care. It is much better if a physician can document a patient being a hospice candidate," she said.

... On Pain

"Pain and other symptoms of discomfort associated with terminal illness can always be alleviated. Pain is only one of many symptoms that beset patients with terminal illnesses. Weakness and fatigue, nausea and vomiting, and depression also are commonly experienced by patients nearing the end of life. Providing relief from these symptoms is one of the primary goals of an interdisciplinary hospice team."

Most pain associated with cancer or other incurable illness yields to straightforward treatment. At times, pain or other distressing symptoms prove difficult to treat and absolute comfort can not be achieved, but it is always possible to make symptoms more tolerable."

— Gerry Ann Houston, M.D.

"Sometimes as physicians we think we're the only person a patient needs," said Dr. Houston. "I think of the hospice team as an extension of myself. Physicians who choose to remain a patient's supervising physician can feel comfortable knowing that our hospice nurses are experts in pain management and symptom control. The result is fewer calls for minor problems such as nausea and restlessness. They are well-trained professionals who report back to me. We are there to help make patients comfortable physically, emotionally, spiritually in the privacy of their own, among their favorite belongings, family, friends, and pets in their final days."

An In-Home Hospice Experience

Dr. Ralph E. Sulser, a Jackson internist, is one of those people who can't say enough good things about hospice care. When his mother, Jean, was diagnosed with end-stage heart and lung disease at age 79 she received in-home hospice care from Hospice Ministries.

"We wanted her to be at home and we knew that hospice could provide moral and medical support. An interdisciplinary team came to my father's home and evaluated her. They informed us when they were coming, what they would be doing, and how they would be helping

to make sure we understood and were in agreement," he said.

"They were great," Dr. Sulser said. "The physical therapists kept her active and assisted with getting her in and out of bed. The nurses practiced wound management to take care of her skin and supplied the necessary wound care products. They supplied nutritional support, various assistive devices including a commode chair and even helped with bowel problems. No job was too big or too small for them. They were willing to help in any way possible. Whatever we needed, they were there to help. It

DIFFERENCES BETWEEN HOSPICE AND HOME CARE

Hospice Care

Hospice is a philosophy of care.

Holistic in approach: nursing, physicians, social services, counseling, spiritual care, therapies, volunteers.

Skilled care not essential.

Homebound status not essential.

Inpatient respite care available.

Bereavement counseling provided.

Written bereavement care plan required.

Care continues if patient lives longer than six months.

Up to 24 hour nursing care (continuous care) at home available for acute pain symptoms.

Patient/family is unit of care.

Patients are terminally ill.

Nurses specialize in pain and symptom management.

Purpose of program is comfort, not cure.

Heavy emphasis on emotional support for client and family.

Home Care

Home care is a method of delivering nursing care.

Nursing involved; other therapies as necessary.

Must be skilled care.

Must be homebound.

No respite care available.

No bereavement counseling.

No care plan required as client is discharged on death and family is not followed.

Discharged when skilled need no longer exists.

24 hour continuous nursing care not available.

Care is client oriented.

Wide range of client problems from newborn to terminally ill.

Nurses use variety of skills.

Purpose of program is rehabilitation and cure.

Emphasis on physical care.

wasn't too long before they felt like part of the family."

Dr. Sulser said, "She was on a number of medications that had to be monitored carefully and they were excellent about making sure she was on the proper regimen and free of complications. But more than that, they provided a wonderful amount of moral support and a remarkable feeling of caring. It was so very meaningful knowing that she felt they really cared about her."

"After she died they came by the funeral home for visitation and/or to the funeral. They called my father afterwards. He went to the building dedication of their lovely, new place and said it felt like a reunion seeing some of the workers."

Bereavement Counseling

"Part of Hospice is providing bereavement support after family members have lost a loved one," said John Fletcher, executive director of Hospice Ministries. Most hospices contact the loved ones and follow them for a year after the death of the patient to help with the grief process and extend any assistance possible to help with their recovery. An extension of Hospice Ministries' bereavement services is the McClean Center.

The New McClean Fletcher Center

Fletcher added, "I can't think of any better way to provide that support than through a center like this for children." The third division of Hospice Ministries, the McClean Center, Mississippi's first grief center for children and their families recently opened at 2624 Southerland Street in Jackson.

Isabel Cordua, the McClean Center's director explained, "It is a place where children can go to express their sadness, anger or guilt. It is a place where they can embrace grief and begin their journey through the healing process toward peace. Our focus is young people six-thirteen years old who have experienced the death of a sibling, parent, grandparent, friend ... any loved person. The service is for all children in the state, not just hospice families. We hope physicians will refer children they feel could use support."

Modeled after the Dougy Center in Portland, Oregon, considered the national standard on children's grief support, it is one of 110 grief centers for children in the United States. An inspiring segment by John Stossell about the Dougy Center appeared on "20/20" illustrating how children help each other through their grief by sharing feelings with other children like themselves who have lost a loved one...feelings they wouldn't share anywhere else.

Joan Schweizer Hoff, M.A., Associate Director of

the Dougy Center, came to Jackson and led a two-day grief support seminar/volunteer training session and explained the model center's mission for grieving children. "We believe every child deserves the opportunity to grieve in a supportive and understanding environment. However, our society fails to understand that. By surrounding them in a safe place with loving support they work to heal themselves."

"Play is an important part of it," she said. "We don't try to fix them, change them, teach them, or perform therapy on them. We just be with them. It is important for children to feel accepted."

The McClean Center is designed with that in mind. Upstairs is a group room where children first go to talk. From there, depending upon their feelings, they can select one of many rooms to continue expressing their emotions. There is a tornado room, an art room, a play room, a game room and even a hiding place for those that want to be alone.

Helen Tester, a Hospice staff member, said the rooms are designed to provide a safe place for children to express themselves with other children in similar situations. The parent or guardian can use an adult support group room downstairs or stay in the lobby.

"We're not a therapeutic center. We're a support group that let's children share their journey," said Tester. "If we see that a child need's individual therapy we will refer them. Here we validate the children's emotions."

The center schedules 90-minute sessions for groups of 13 to 15. The first group started in November and had eight children made up of some younger 7- to 8-year-olds and some older 11-, 12-, and 13-year-olds. Cordua said they are receiving more referrals for teenagers and will have to include them sooner than they expected as will 3- to 5-year-olds. In addition, support groups will probably be separated later by types of loss, like those who have had loved ones die from homicide and suicide.

The McClean Center is named in honor of McClean Fletcher, who died in 1996, the result of injuries received in an automobile accident. "McClean was 19-years-old and had committed her future to loving and caring for children, although she herself was just a child. McClean exemplified the spirit and philosophy of The Center's mission through her passion for life, her compassion for children, the gift of mentoring, and her intuitive ability to touch the hearts of those in need," said Cordua. McClean was the daughter of Hospice Ministries' Executive Director John Fletcher, and his wife, Sally.

Although services are free, donations are accepted and volunteers are wanted. The Junior League of Jackson is providing funding, volunteers and help in educating the

public about the center. All programs will serve as a resource to the entire state.

The McClean Center programs encourage kids to share their experience with other kids in the program, and the children are supported by professional staff and trained volunteers as they begin their journey through the healing process. Family members or guardians may participate as well. A separate McClean Center program addresses the specific needs of adults while children participate in programs with other kids.

Dr. Causey commented, "Think what a good service it would have provided the students in Pearl if it had been here two years ago."

Other Hospices in Mississippi

While non-profit Hospice Ministries is one of the oldest and largest hospices in Mississippi and its inpatient division is one of the largest in the United States, many other in-home hospice organizations exist. A complete list of those certified and licensed per House Bill #379 enacted by the regular 1995 Session of the Legislature of the State of Mississippi requiring the Mississippi State Department of Health (MSDH) to adopt Minimum Standards of Operation for Hospice follows.

According to Steve Egger, branch manager for the MSDH Licensure and Certification Division, the only other inpatient hospices are Heartfelt in Meridian and SouthernCare in Brookhaven.

These will soon be joined by Hospice Care Foundation, Inc. (HCF), a non-profit, in-home agency with regional outreach currently constructing a 60 bed inpatient hospice in Vicksburg which, when completed, will be the largest facility of its kind in the state. Pat Fordice, First Lady of the state of Mississippi, serves as Chairperson for this project. HCF Coordinator for Special Services Carla Walsh said, "The new, inpatient facility will include a children's unit and will serve those who may not have a caregiver in the home." Currently, HCF has 18 offices in Mississippi, Arkansas, and Louisiana.

Most of the other in-home hospice services are affiliated with home health agencies with the exception of hospital-based North Mississippi Medical Center (NMMC) Hospice, the first licensed hospice in the state, according to Paula Turner, a NMMC customer advocate.

Mississippi Hospice Organization (MHO)

The Mississippi Hospice Organization was organized in 1990 and provides a forum for the member hospices to learn more about symptom control and supportive care.

Mary H. Nichols, RN, OCN, CHRN, Director, Baptist Memorial Hospice, Columbus serves as secretary for the MHO. Nichols said, "The organization was instrumental in helping to write the licensure regulations in the early 1990's."

She said the organization is currently emphasizing the development of a Code of Ethics based upon that adopted by the National Hospice Organization. "Until three years ago Joint Commission (JCAHO) accreditation was not available to hospices. Many MHO members are already accredited and most of the regulations of licensure and accreditation are based upon the regulations included in the original HCFA guidelines for hospice. Emphasis is always on the provision of quality, interdisciplinary care to patients and their families who are experiencing terminal illness," she said.

"But, the problems faced by hospices all over the country are the same: referrals made within hours or days of death, preconceived ideas that referral or admission to hospice means that death is imminent, fear of sanctions for prescribing adequate amounts of narcotics to control pain, knowledge deficits related to hospice services and benefits, inadequate funding, regulations that are themselves prohibitive and timidity in facing the reality of death with patients and families," she said.

Nichols hopes the current emphasis on end-of-life care may do much to eliminate some of these problems and that reduced funding and restrictions being placed on traditional health care may make referral to hospice a more acceptable option. "We continue to experience difficulties. Most of the physicians fully support hospice and refer patients frequently. But, we still have physicians who fear prescribing narcotics. Some physicians still want to have very sick patients transported to their offices by ambulance before treating even a urinary tract infection."

"We continue to admit patients who are actively dying," she said. "We hear our families asking, 'Why didn't we know about hospice sooner?'"

Nichols told me a story and I ask her if I could repeat it. It bears mentioning... "Once I had a physician in a nearby town tell me that he can do anything for his patients that hospice can do. We proceeded to have a rather heated discussion. When I told him that registered nurses visit at least twice a day, he said he makes house calls whenever he is needed. I told him we were available twenty-four hours a day; he said so is he. We continued to banter back and forth. I finally said, 'Okay, if you do make a house-call and identify that the patient has an impaction, are you going to do what you have to do to fix

it?" He quickly replied, "No!" I said simply, "We do." He admitted that I had him on that one."

Nichols doesn't want to be misunderstood; however, "There are many physicians who consider us their partners in the care of their patients, who express their appreciation to us when we apologize for calling at midnight. There are many who resent the loss of control and the loss of revenue. It would be better if they understood how their patients and their families can benefit greatly from the symptom control provided by and the interdisciplinary supportive care available through hospice."

National Hospice Organization (NHO)

The National Hospice Organization was founded in 1978 as a nonprofit public-benefit charitable organization advocating for the needs of terminally ill persons in America. NHO is the largest independent national nonprofit membership organization devoted exclusively to the promotion of hospice care in the U.S.

While admission to hospice continues to require the determination by a physician of a prognosis of six months or less, National Hospice Organization and other people and organizations who are active in hospice are advocating an extension to a prognosis of one year or less. The extension of the prognosis from six months to one year would expand the availability of hospice care to many more individuals who are experiencing their final weeks and months.

As of 1999, 44 states have hospice licensure laws. In 1999, NHO's membership includes over 2,100 hospice programs, 47 state hospice organizations, and 4,000 individuals.

Statistics: *Mississippi Hospice Association
Hospice Association of America*

HOSPICE COSTS, SAVINGS AND REVENUE

There is no nationwide standard on what the cost of caring for a hospice patient is. The closest determination is Medicare per diem rates which for FY 1997 were around \$94.17 per day for home care and \$418.93 per day for general inpatient care.

More than 90% of hospice care hours are provided in patient's homes, thus substituting for more expensive multiple hospitalizations.

ORGANIZATIONAL STRUCTURE AND ADMISSIONS

In 1998, approximately 28% of hospices are independent hospice corporations, 59% are divisions of a corporation other than a hospice, and 13% are unidentified. Of the 59% that are divisions, 30% are divisions of hospitals; 19% are divisions of home health agencies; 6% are divisions of hospice corporations; 1% are divisions of nursing homes; and 3% are divisions of "other" corporations.

In 1998, 66% of hospices are nonprofit; 4% are government organizations; 18% are for-profit; and 12% are unidentified.

In 1998, 24% of hospices have operational budgets less than \$250,000, 12% have budgets between \$250,000-499,000, 11% have budgets between \$500,000-999,999, 15% have budgets between \$1-3.9 million, 3% have budgets between \$4-6.9 million, 1% have budgets between \$7-9.9 million, 1% have budgets greater than \$10 million, and 33% are unidentified.

PATIENT INFORMATION (1995 NHO CENSUS)

In 1995, 60% of hospice patients had cancer; 6% heart-related diagnoses; 4% had AIDS; 1% renal (kidney) diagnoses; 2% Alzheimer's; and 27% "other."

In 1995, hospices cared for about one out of every two cancer deaths in America.

In 1998, the average length of stay was 51.3 days. In 1998, the median length of stay was 25 days.

The 1995 sources of payment (presented as a percentage of patients) for hospice services are as follows: Medicare, 65.3%; private insurance, 12%; Medicaid, 7.8%; indigent (nonreimbursed) care, 4.2%; other, 10.7%.

In 1995, 52% of hospice patients are male; 48% female. Of male patients, 71% were 65 or older; 17.2% between 50-64; 10% were 18-49; and 1% were 17 or younger. Of the female patients, 74% were 65 or older; 16.7% between 50-64; 8.6% were 18-49; and 1% were 17 or younger.

Consistent with other health care census statistics, in 1995, 83% of hospice patients were white; 8% were African American; 3% Hispanic; and 6% were identified as "other."

Directory of MSDH Certified Hospice Health Care Facilities

The Mississippi State Department of Health *Directory of Health Care Facilities* (July 1999) provides information about those in Mississippi that are licensed and/or certified for participation in the Medicare and/or Medicaid Programs by the Division of Health Facilities Licensure & Certification. The following are those that are listed (as of press date Dec. 8, 1999) as Certified Hospice:

***Baptist Memorial Hospice/
Home Care Columbus**

Mary Holt Nichols, Administrator
2250 5th Street North
P.O. Box 1307
Columbus, Mississippi 39703
Phone: 243-1173

***Baptist Memorial Home Care-
Oxford-Hospice Division**

Sharon Johnson, Administrator
703A North Lamar
Post Office Box 1494
Oxford, MS 38655
Phone: 234-8553

***Baptist Memorial Home Care/
Hospice Division**

Donna Noe, Administrator
396 Southcrest Court 45
Southaven, MS 38671
Phone: 349-1394

Charity Hospice

581 Medical Drive
P.O. Box 1887
Clarksdale, MS 38614
Phone: 627-7163

Community Hospice Care

P.O. Box 276
401 Bailey Avenue
Hollandale, MS 38748
Phone: 827-2765

***Comfortcare Hospice**

Tom Canizaro, Administrator
616 E. 19th Street
Post office Box 607
Laurel, Mississippi 39441
Phone: 422-0054

DHS Hospice Care

Jorja Vogel, Administrator
187 Stateline Road
P.O. Box 744
Southaven, MS 38671
Phone: 280-8200

Delta Area Hospice Care, LTD

522 Arnold Avenue
Post Office Box 5915
Greenville, Mississippi 38704
Phone: 335-7040

***Delta Regional Medical**

1314 Hospital Street
Greenville, Mississippi 38704
Phone: 334-2154

Family Hospice Care, Inc.

376 Liberty Road
Natchez, MS 39120
Phone: 442-7170

Family Hospice of Jackson

103 Sunrise Point Drive
Brandon, MS 39047
Phone: 919-1115

***Forrest General Home Care
Hospice**

Patricia J. Snead, Administrator
1414 South 28th Avenue
Hattiesburg, MS 39402
Phone: 288-2500

**Center Hospice Agency
Genesis Hospice Care, Inc.**

210 W. Sunflower Road
P.O. Box 1888
Cleveland, MS 38732
Phone: 846-0100

Heartfelt Hospice

P. O. Box 1520
1520 Posey Avenue
Philadelphia, MS 39350
Phone: 650-9666 1-888-881-0551

Hometown Hospice, Inc.

8366 Hwy 19 North
Collinsville, MS 39325
Phone: 626-7277

***Horizon Hospice**

317 Canal Street
McComb, MS 39648
Phone: 250-0884

Hospice Care at Home

5930 Fountain Park Drive
Jackson, MS 39206
Phone: 713-0061

***Hospicare, Inc.**
546 Menge Avenue
Pass Christian, Mississippi 39571
Phone: 452-4301
Voice Mail: 1-800-881-9905

***Hospice Care Foundation, Inc.**
Ida J. Haworth, Administrator
317 Highland Avenue Suite B
Natchez, Mississippi 39120
Phone: 442-3070

***Hospice Care Foundation, Inc.**
Ida J. Haworth, Administrator
P.O. Box 910
Vicksburg, MS 39181
Phone: 634-6672

Hospice Division of South Mississippi Home Health, Inc.
108 Lundy Lane
Post Office Box 15788
Hattiesburg, Mississippi 39404
Phone: 261-4010

***Hospice Ministries, Inc. (Inpatient)**
John C. Fletcher, Exec. Director
Post Office Box 1228
450 Town Center Boulevard
Ridgeland, Mississippi 39158-1228
Phone: 898-1053
1-800-273-7724

***Hospice Ministries, Inc. (In-Home Divisions)**
John C. Fletcher, Exec. Director
450 Town Center Boulevard
Ridgeland, Mississippi 39157
Phone: 898-1053
224 South First Street
Brookhaven, Mississippi 39601
Phone: 835-1020
2069 Highway 35 South
Forest, Mississippi 39074
Phone: 469-2141
1-888-405-2216
118 Lower Woodville Road, Suite 19
Natchez, Mississippi 39121
Phone: 446-8000
1-800-680-0448

***Hospice Ministries, Inc. (In-Home Divisions continued)**
3530 Manor Drive, Suite 3
Vicksburg, Mississippi 39180
Phone: 661-0021
1-888-718-0021

***Hospice of Light**
John J. Cleary, Administrator
4341 Gautier-Van Cleave Road
Gautier, Mississippi 39553
Phone: 497-2400

***Hospice of North Mississippi**
103 Main Street
Sardis, MS 38666
Phone: 487-3447 (Licensed Only)

***Hospice South of Meridian, LLC**
1010 19th Avenue, Suite 1-2
Meridian, MS 39303
Phone: 482-7947

***Memorial Hospital at Gulfport Hospice**
4500 13th Street
P.O. Box 1810
Gulfport, Mississippi 39501
Phone: 867-4160

***Mercy Hospice of Mississippi**
102 West Spring Street
Ripley, MS 38663
Phone: 837-9990

***North Mississippi Medical Center Hospice**
Laura Kelly, Administrator
600 West Main
Tupelo, Mississippi 38801
Phone: 841-3612

Pro-Care Hospice
P.O. Box 527
Highway 15 Bay Avenue
Bay Springs, MS 39422
Phone: 764-2081

***Quality Hospice of the Gulf Coast, Inc.**
Patricia Hiers, Administrator
999 Howard Avenue
Post Office Box 549
Biloxi, Mississippi 39530
Phone: 374-4434

Saad's Hospice Services of MS
814 Vieux Marche
Biloxi, MS 39530
Phone: 432-8855

***Seyah Hospice Care, Inc.**
813 West Grand Avenue
Post Office Box 231
Inverness, Mississippi 38753
Phone: 265-5333

***SouthernCare Hospice of Brookhaven**
P.O. Box 1394
305 N. Jackson Street
Brookhaven, MS 39602-1394
Phone: 833-8828

***Southern Care Newton, Inc.**
105 East 1st Street
Newton, MS 39345
Phone: 683-7500

***Southern Care Pascagoula**
4211 Hospital Road, Suite 206 P
Pascagoula, MS 39581
Phone: 769-6132

***Southern Sta-Home Hospice**
2008 Pass Road, Suite A
Biloxi, MS 39531
Phone: 338-3226

***Sta-Home Hospice, Inc.**
Claudette Hathcock, Administrator
406 Briarwood Drive, Suite 500
Jackson, MS 39206
Phone: 991-1933

***Superior Home Health & Hospice**

Ann Walker, Administrator
3001 Hwy 72 West
Corinth, Mississippi 38834
Phone: 286-4244

Trinity Hospice

154 Porter Avenue
Biloxi, MS 39530
Phone: 435-1948

***Wayne General Hospice**

920 Matthew Drive
Waynesboro, MS 39367
Phone: 735-7133

***We Care Hospice**

3737 Main Street
Moss Point, MS 39563
Phone: 474-2030

**Licensed Only
Hospice
(Certified by Other
States)**

***Alliance Health Services, Inc.**
d/b/a Alliance Hospice
6400 Shelby View Drive
#101 Memphis, TN 38134
Phone: (901) 680-0169

Slidell Memorial Hospice
1045 Florida Avenue
Slidell, Louisiana 70458
Phone: (504)-847-0174

*** member of the Mississippi
Hospice Organization (MHO)**

Medicare Hospice Benefit

Hospice care is a special way of caring for a patient whose disease cannot be cured. It is available as a benefit under Medicare Hospital Insurance (Part A). Medicare beneficiaries who choose hospice care receive non-curative medical and support services for their terminal illness.

To be eligible, they must be certified by a physician to be terminally ill with a life expectancy of six months or less. While they no longer receive treatment toward a cure, they require close medical and supportive care which a hospice can provide. Hospice care under Medicare includes both home care and inpatient care, when needed, and a variety of services not otherwise covered by Medicare. The focus is on care, not cure. Emphasis is on helping the person to make the most of each hour and each day of remaining life by providing comfort and relief from pain.

WHAT IS HOSPICE CARE?

Under Medicare, hospice is primarily a program of care delivered in a person's home by a Medicare - approved hospice. Reasonable and necessary medical and support services for the management of a terminal illness are furnished under a plan-of-care established by the beneficiary's attending physician and the hospice team.

Medicare covers:

- physicians' services
- nursing care (intermittent with 24-hour on call)
- medical appliances and supplies related to the terminal illness
- outpatient drugs for symptom management and pain relief
- short-term acute inpatient care, including respite care
- home health aide and homemaker services
- physical therapy, occupational therapy and speech/language pathology services
- medical social services
- counseling, including dietary and spiritual counseling

WHO IS ELIGIBLE?

Hospice care is available under Medicare only if:

- The patient is eligible for Medicare Hospital Insurance (Part A)
- The patient's doctor and the hospice medical director certify that the patient is terminally ill with six months or less to live if the disease runs its expected course
- The patient signs a statement choosing hospice care instead of standard Medicare benefits for the terminal illness
- The patient receives care from a Medicare-approved hospice program

WHO CAN PROVIDE HOSPICE CARE?

Hospice care can be provided by an agency or organization that is

primarily engaged in furnishing services to terminally ill individuals and their families. To receive Medicare payment, the agency or organization must be approved by Medicare to provide hospice services.

Approval for hospice is required even if the agency or organization is already approved by Medicare to provide other kinds of health services. Patients can find out whether a hospice program is approved by Medicare by asking their physician or checking with the agency or organization offering the program. This information also is available from local Social Security offices.

Hospice uses a team approach that includes the patient and family, nurses, social workers, physicians, clergy and volunteers, all working together to plan and coordinate care. Family or friends (serving as primary caregivers) in the home can call for the help of a hospice team member 24 hours a day, 7 days a week. The team member will come to the patient's home whenever needed and appropriate. The hospice team can arrange for a transfer to another setting when necessary.

HOW LONG CAN HOSPICE CARE CONTINUE?

Special benefit periods apply to hospice care. A Medicare beneficiary may elect to receive hospice care for two 90-day periods, followed by an unlimited number of 60-day periods. The benefit periods may be used consecutively or at intervals. Regardless of whether they are used one right after the other or at different times, the patient must be certified as terminally ill at the beginning of each period.

A patient who chooses hospice care may change hospice programs once each benefit period. A patient also has the right to cancel hospice care at any time and return to standard Medicare coverage, then later re-elect the hospice benefit in the next benefit period. If a patient cancels during one of the first three benefit periods, any days left in that period are lost.

HOW IS PAYMENT MADE?

Medicare pays the hospice directly at specified rates depending on the type of care given each day. The patient is responsible only for:

- Drugs or biologicals: The hospice can charge 5 percent of the reasonable cost, up to a maximum of \$5, for each prescription for out-patient drugs or biologicals for pain relief and symptom management related to the terminal illness.
- Inpatient Respite care: The hospice may periodically arrange for inpatient care for the patient to give temporary relief to the person who regularly provides care in the home. Respite care is limited each time to a stay of no more than 5 days. The charge (currently 5%), which is subject to change each year, varies slightly depending on the geographic area of the country.

ARE OTHER MEDICARE BENEFITS AVAILABLE?

When Medicare beneficiaries choose hospice care, they give up the right to standard Medicare benefits only for treatment of the terminal illness. If the patient, who must have Part A in order to use the Medicare hospice benefit, also has Medicare Part B, he or she can use all appropriate Medicare Part A and Part B benefits for the treatment of health problems unrelated to the terminal illness. When standard benefits are used, the patient is responsible for Medicare's deductible and coinsurance amounts.

WHAT IS NOT COVERED?

All services required for treatment of the terminal illness must be provided by or through the hospice. When a Medicare beneficiary chooses hospice care, Medicare will not pay for:

- Treatment for the terminal illness which is not for symptom management and pain control
- Care given by another healthcare provider that was not arranged for by the patient's hospice
- Care from another provider which duplicates care the hospice is required to provide.

To determine whether a Medicare-approved hospice program is available in your area, contact the nearest Social Security Administration office, your state or local health department, your state hospice organization, or call the National Hospice Organization Hospice Information Line (800) 658-8898.

* Portions excerpted from the Medicare Hospice Benefit a publication of: U.S. Department of Health and Human Services, Health Care Financing Administration.

Hospice Criteria for Diseases (Other Than Cancer)

AIDS

The following factors are correlated with early mortality and therefore may be helpful when evaluating a patient for terminal care. Most hospices stipulate the patient cannot be on AZT or protease inhibitors:

I. CD4+ Count

- A. Patients whose CD4+ count is below 25 cells/mcL, or persistent viral load > 100,000 copies/ml measured during a period when patient is relatively free of acute illness, may have a prognosis less than six months, but should be followed clinically and observed for disease progression and decline in recent functional status.
- B. Patients with CD4+ count above 50 cells/mcL probably have a prognosis longer than six months unless there is a non-HIV-related co-existing life-threatening disease.

II. Viral Load

- A. Patients with a persistent HIV RNA of >100,000 copies/ml may have a prognosis less than six months.
- B. Patients with lower viral loads may have a prognosis of less than six months if:
 1. They have elected to forego antiretroviral and prophylactic medication.
 2. Their functional status is declining.
 3. They are experiencing complications listed in IV below.

III. Life-threatening complications with median survival: The following HIV-related opportunistic diseases, all are associated with prognosis less than six months if patient does not elect treatment.

- A. CNS lymphoma
- B. Progressive multifocal leukoencephalopathy
- C. Cryptosporidiosis
- D. Wasting (loss of 33% lean body mass)
- E. MAC bacteremia, untreated
- F. Visceral Kaposi's sarcoma unresponsive to therapy
- G. Renal failure, refuses or fails dialysis
- H. Advanced AIDS dementia complex
- I. Toxoplasmosis

IV. The following factors have been shown to decrease survival significantly and should be documented if present:

- A. Chronic persistent diarrhea for one year, regardless of etiology.
- B. Persistent serum albumin <2.5 gm/dl.
- C. Concomitant substance abuse.
- D. Age greater than 50.
- E. Decisions to forego antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease.
- F. Congestive heart failure, symptomatic at rest.

ALS

The following factors may define ALS patients with expected survival of approximately six months:

I. Rapid progression of ALS and critically impaired ventilatory capacity.

A. Rapid progression of ALS (within the last year).

1. Progressing from independent ambulation to wheelchair or bed-bound.
2. Progressing from normal to barely intelligible speech.
3. Progressing from normal to blenderized diet.
4. Progressing, from independence in most ADL's to needing, major assistance by caretaker.

B. Critically impaired ventilatory capacity (within the past six months)

1. Vital Capacity less than 30% of predicted,
2. Significant dyspnea at rest.
3. Requiring supplemental oxygen at rest.
4. Patient declines intubation or tracheostomy and mechanical ventilation.

II. Rapid progression of ALS and critical nutritional impairment.

A. Rapid ALS progression as described above.

B. Critical nutritional impairment, if oral intake of nutrients and fluids is insufficient to sustain life, documented by continued weight loss, dehydration or hypovolemia.

III. Rapid progression of ALS and life-threatening complications.

A. Rapid ALS progression as described above.

B. Life-threatening complications, such as recurrent aspiration pneumonia, Stage 3-4 decubitus ulcers, upper urinary tract infection, sepsis, or fever recurrent after antibiotics.

*NOTE: While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six month prognosis.

COMA & STROKE

Continuous decline in clinical or functional status over time means that the patient's prognosis is poor and is probably a candidate for hospice and supportive care.

I. During the acute phase immediately following a hemorrhagic or ischemic stroke, any of the following are strong predictors of early mortality:

A. Coma or persistent vegetative state beyond three days' duration.

B. In post-anoxic stroke, coma or severe obtundation, accompanied by severe myoclonus, persisting beyond three days past the anoxic event.

C. Comatose patients with any 4 of the following on day 3 of coma:

1. Abnormal brain stem response
2. Absent verbal response
3. Absent withdrawal response to pain
4. Serum creatinine >1.5 mg/dl
5. Age >70

D. Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life, in a patient who declines, or is not a candidate for, artificial nutrition and hydration.

II. Once the patient has entered the chronic phase, the following factors should be documented:

- A. Age >70.
- B. Poor functional status as evidenced by score of <50% on Karnofsky scale.
- C. Post-stroke dementia as evidenced by a FAST score of greater than 7.
- D. Poor nutritional status, whether on artificial nutrition or not, with inability to maintain sufficient fluid and calorie intake with weight loss > 10% during the prior six months or serum albumen < 2.5 gm/dl
- E. Medical complications, such as aspiration pneumonia, UTI's, sepsis, stage 3-4 decubitus ulcers, or fever recurrent after antibiotics.

DEMENTIA

Very advanced dementia patients can survive for long periods with meticulous care. Thus, prediction of sixmonth mortality is challenging. The following criteria reflect characteristics of both, Alzheimer's patients and advanced dementia patients.

I. Hospice appropriate patients should exhibit all of the following:

- A. Unable to ambulate without personal assistance. This is a critical factor.
- B. Unable to dress without assistance
- C. Unable to bathe without assistance
- D. Urinary and fecal incontinence
- E. No meaningful verbal communication stereotypical phrases only; or ability to speak is limited to six or fewer intelligible words

II. Documentation within the last year or complications which may decrease survival, whether or not the decision was made to treat the condition:

- A. Aspiration pneumonia
- B. Upper urinary tract infection or pyelonephritis
- C. Septicemia
- D. Decubitus ulcers, multiple, stage 3-4
- E. Fever recurrent after antibiotics
- F. Difficulty- swallowing food or refusal to eat, so severe that patient cannot sufficiently maintain fluid and caloric intake to sustain life, with patient or surrogate refusing tube feedings or parenteral nutrition. Patients receiving tube feedings must have documented unintentional, progressive weight loss of greater than 10% over prior 6 months.

HEART DISEASE

The following criteria may be used to predict mortality within approximately six months, assuming the disease runs its normal course:

I. Symptoms of recurrent congestive heart failure (CHF) at rest.

- A. These patients are classified as New York Heart Association (NYHA) Class IV
- B. Ejection fraction of 20% or less is helpful supplemental objective evidence, but should not be required if not already available.

II. Patients should already be optimally treated with diuretics and vasodilators, preferable angiotensin converting enzyme (ACE) inhibitors.

- A. The patient experiences persistent symptoms of congestive heart failure despite attempts at maximal medical management with diuretics and vasodilator.
- B. "Optimally treated" means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g. hypotension or renal disease.
- C. Although newer beta blockers with vasodilator activity, e.g. carvedilol, have recently been shown to decrease morbidity and mortality in chronic CHF, they are not included in the definition of "optimal treatment" at this time.

III. Each of the following factors has been shown to decrease survival further:

- A. Arrhythmias that are resistant to antiarrhythmic therapy.
- B. History of cardiac arrest and resuscitation in any setting.
- C. History of unexplained syncope.
- D. Embolic CVA of cardiac origin.
- E. Concomitant HIV disease.

PULMONARY

Determining prognosis in end-stage lung disease is extremely difficult. Patients who fit the following parameters can be expected to have the lowest survival rates. It is uncertain what number or combination of these factors might predict six-month mortality.

I. Severity of chronic lung disease documented by:

- A. Disabling dyspnea at rest, poorly responsive to bronchodilators, resulting in decreased functional activity and often exacerbated by other symptoms such as fatigue and cough. (FEV1 of less than 30% predicted after use of bronchiodators is useful but not necessary.)
- B. Progressive pulmonary disease as evidenced by:
 - 1. Prior increasing visits to ER or prior hospitalizations for pulmonary infections and/or respiratory failure.
 - 2. Decrease in FEV1 on serial testing of greater than 40 ml. per year is objective evidence for disease progression, but is not necessary to obtain.

II. Presence of Cor Pulmonale or Right Heart Failure.

- A. Due to advanced pulmonary disease, not primary or secondary to left heart disease or valvulopathy.
- B. These studies are helpful but not required:
 - 1. Echo cardiogram
 - 2. EKG
 - 3. Chest X-ray
 - 4. Physical signs of RHF

III. Hypoxemia at rest on room air as evidenced by:

- A. pO₂ less than or equal to 55 mm. Hg or
- B. Oxygen saturation less than or equal to 88%. These values may be obtained from recent hospital records or
- C. Hypercapnia (pCO₂ equal to or greater than 50 mm Hg.) This value may be obtained from recent hospital records.

IV. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

V. Resting tachycardia greater than 100/minute in a patient with known severe COPD.

RENAL

The patient should not be seeking dialysis or renal transplant. Patients are generally appropriate for hospice services if they fit dialysis criteria.

I. Laboratory criteria for renal failure.

- A. Creatinine clearance of less than 10cc/min (less than 15cc/min for diabetics) AND
- B. Serum creatine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetics).

II. Clinical signs and syndromes associated with renal failure.

- A. Uremia: clinical manifestations of renal failure.

- 1. Confusion, obtundation
- 2. Intractable nausea and vomiting
- 3. Generalized pruritis
- 4. Restlessness, "restless legs"

- B. Oliguria: urine output less than 400cc/24 hrs.

- C. Intractable hyperkalemia: persistent serum potassium >7.0 not responsive to medical management.

- D. Hepatorenal syndrome.

- E. Uremic pericarditis.

- F. Intractable fluid overload.

III. In hospitalized patients with ARF, these comorbid conditions predict early mortality:

- A. Mechanical ventilation.

- B. Malignancy-- other organ systems.

- C. Chronic lung disease.

- D. Advanced cardiac disease.

- E. Advanced liver disease.

- F. Sepsis.

- G. AIDS

- H. Albumin <3.5 gm/dl.

- I. Cachexia.

- J. Platelet count <25,000.

- K. Age >75.

- L. Disseminated intravascular coagulation.

- M. Gastrointestinal bleeding.



W. Briggs Hopson, Jr., M.D.
The President's Page

A New Beginning

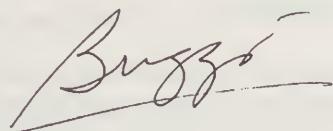
“**T**he King is Dead, Long Live the King”

The above is a familiar saying on the evolution of one reign to the next. And so, as we send out the old 20th century and welcome in the 21st century let us truly ask ourselves, what can the coming generation of physicians look forward to?

First, hopefully they will build upon the past, for what is old is new again, and what is new is old again. An excellent example of this is the Medical Practice Act which guarantees patients' rights. Although passed slightly over 100 years ago, it was instrumental in developing a code of ethics in which the physicians pledged themselves to care for those who were unable to care for themselves financially and to enlighten people on the prevention of communicable diseases. Even today, we can continue to work on ethics in medicine and try to educate people on communicable diseases such as AIDS, hepatitis C, etc. The list goes on and on. But let us look at what is new is perhaps old again. In this regard, let's look at the AMA's new vision on collective bargaining. Over 100 years ago in the *Journal of the Mississippi State Medical Association* the following was written: “All professions, trades, and callings protect themselves by associations, unions, etc., except the doctors, and it has come to be a reproach to us that there is less cohesion, more bickering, less brotherly regard, and less business sense among ourselves than is found in any other learned profession. In union there is strength is a proverb as true as it is trite. If we could weld the doctors of Mississippi into one active harmonious body, acting under the inspiration to keep our state up with the foremost in all that pertains to our profession, we would not have long to wait before our endeavors would reach fruition. In this vein, I urge a federation of state societies and state unions on a plan adopted by the national association.” These new thoughts to us were, again, debated over 100 years ago and yet they still ring true today. Secondly, let's not just build upon the past but, as the saying goes, let's let the dead past bury the dead and act in the living presence. For in the living presence we have the future to look to, a future that is perhaps the brightest that it has ever been in medicine. There have been more changes in the last 10 years of the 20th century than in the 90 years before that. We have seen astronomical changes with regard to noninvasive, computerized laser, virtual reality type

medicine and this will only get better as we approach the 21st century. With young minds being more creative, more enthusiastic, and more energetic, the future of medicine looks boundless. I believe that the great minds of the young will conquer the diseases that we most fear now, those diseases being heart disease, cancer, stroke, and certainly trauma. A large portion of this will come through preventive medicine, although certainly modern technological changes will be second as we progress into the 21st century.

I, as one who looks forward to laying down the gauntlet, know that there are those behind me who are eagerly awaiting to pick it up and run with it. And that delights my heart... knowing that challenges will not only be challenges but accomplishments yet unfulfilled.

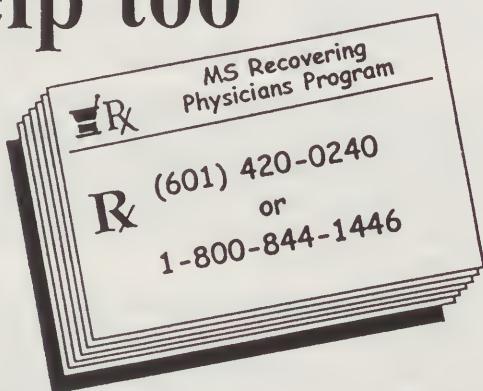


UNKEMPT APPEARANCE BEHAVIORIAL CHANGES BLOOD-SHOT/BLEARY EYES NOT THE SAME GUY HE USED TO BE UNAVAILABLE ON CALL UNUSUAL HIGH DOSE OR USAGE NOTED IN DRUG USE

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MISSISSIPPI IS BLESSED BY HMO FAILURE

The era of the health maintenance organization, better known by its acronym HMO, seems to have largely bypassed Mississippi. Here in the state, HMOs are closing at a rapid pace, and many of the ones still in business are losing large sums of money. Six of the most active HMOs in the state lost more than \$26 million last year, which follows a national trend. Mississippi does not appear to be a conducive environment for HMOs, and this is a good thing, most physicians will agree, for both Mississippi patients and its physicians. Patient choice of physician and physician control of medical decisions will hopefully be further strengthened by the demise of HMOs.

There were many reasons HMOs failed here. Legislative restrictions and high-risk enrollees are often cited. But most critical was what many consider a disadvantage: Mississippi is a rural state, with many physician shortage areas. This may be a disadvantage in some ways, but it was a blessing for Mississippi in regard to the HMOs. If a small community has only two doctors and neither signs for a certain HMO, that HMO has no offerings for its members in that community. As well, this rural nature made difficult for the HMOs to provide an inclusive panel of physicians and hospitals for their memberships. All of this prevented workable and attractive statewide networks for the HMOs.

The best incentive HMOs offer to physicians is what is called "steerage," or the directing of HMO patients to one's practice. This was less important in Mississippi's rural towns. Many rural physicians have no desire for more patients to be steered their way; most are overworked already, and this benefit proved to be little incentive. Also, many of Mississippi's physicians have been leery to sign agreements with these organizations. Their fears are good ones: reimbursement is often low and regulations many. MSMA saw the HMO trend coming in the 1980s and attempted to create a physician friendly HMO in the state rather than let outside corporations dictate to local physicians. This HMO, created in 1986, operated only a year, and like so many other of the state's HMOs, failed in the medical market, with expenses exceeding income.

Not only have the HMOs largely failed here, but Mississippi may further prove to be a thorn in the side of HMOs. Mississippi's millionaire tobacco litigation lawyers, Richard "Dickie" Scruggs and Hiram Eastland, are targeting Aetna, U. S. Healthcare and other major HMOs, alleging that HMOs use extortion to secure property rights to which they are not entitled and make direct and subtle threats to doctors to cut needed medical services. These Ole Miss frat brothers will make health waters across the nation rough and unfriendly for the HMOs. And whatever one's feelings about these coming HMO lawsuits, public opinion will focus on HMO profits and the importance of the physician's role in medical decision-making.

Is managed care finished in Mississippi? No. I'm afraid that awkward and bureaucratic beast is here to stay. But Mississippi seems to have passed over the worst of the HMO era without significant harm to its health structure. Managed care of different types will continue to operate in the state, with PPOs (preferred provider organizations) and point of service contracts the plans of the future. Mississippi patients will pay higher deductibles but will have more choice with their physician networks.

It is encouraging to reflect that here is one battle physicians and patients have won or seem to be winning. For managed care to work for patients, physicians have to be in charge of their medical care. This now seems to be better understood in the state and nation. Good-bye HMOs and good riddance.

— Lucius Lampton, M. D.
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

[This editorial is offered as a reprint of the President's column in the December 1999 issue of the Mississippi Academy of Family Physicians (MAFP) "Magnolia Family Physician" newsletter. —Ed.]

PIGs, PACs AND PIECES OF PIE

"If you think it's easy to be a politician, try to straddle a fence and keep both ears to the ground at the same time" —The Globe and Mail

Many of you today could care less about the subject of politics. Truth be known, perhaps a majority of you would rather tune out right about now. Ms. Manners might say, "Gentle Doctor, apathy is a luxury you can ill-afford." The climate of health care practice and reimbursement is changing so rapidly that we can no longer as individual physicians rest on our proverbial laurels, sitting back in our safe little clinics and hospital lounges thinking that we are "above all this mess" or that we "don't have time to get involved". Just listen to your compatriots next time you happen into a doctor's lounge scenario. What you will hear is the same "gripe-fest" you've heard since your first week of practice with minor modifications. Gentlemen, I feel that it is time we stopped damning out problems and begin to do our damndest to solve them.

It has been said that "in this life, all is politics". The question "what have you done for me lately?" comes to the fore in workaday politics not only among your office staff, but with your kids at home. And physicians are supposed to be good at developing trust and cultivating relationships with people. If we were only able to carry those finely honed clinical skills over into other realms of our existence!

This summer at our annual business session in Callaway Gardens, we discussed the idea of forming a MAFPPAC. Much careful consideration was given to the notion. Several individual state FP chapters have PACs. Texas AFP, for example, has had a very effective PAC for ten years. I think that it's quite interesting to note that at the national level, the AAFP does not "do a PAC". At the big meeting in Orlando the AAFP voted after heated debate to pursue its political agenda the way it has for the past 50 years-without a Political Action Committee- AAFP Immediate. Past-President Neil Brooks warned the delegate physicians that ... "creating a PAC could actually be a set-back for FPs, who already have the ears of key policy makers in Washington. Once you have a PAC, unless you are willing to pay, you don't have that ear."

Our Executive Director Dr. Bob Graham had this to say... "In my experience in Washington, there are certain expectations of organizations that have PACs that are different from those that don't. Even if the AAFP PAC could raise \$500,000 (annually) that is a pittance in Washington." It was noted that the AAFP carries clout and credibility on Capitol Hill because of its consistent support of policy that focuses on broad public interests, rather than narrow professional interests. Dr. Graham added, "We're viewed as a truthful, public-spirited organization. We say the same things to Democrats as Republicans."

The long-haul of it is that our kindred Mississippi Medical group the MSMA, recognizing that we as family docs across the Magnolia State comprise quite a few vertebral bodies in their backbone, have devised a plan to let MAFP members who are MMPAC contributors to earmark our monies for causes that are most near and dear to us. I truthfully think it is in this organization's best interest not to fragment ourselves from our state medical society as many others have.

Dr. George Merck, founder of the pharmaceutical company bearing his name, had these words of wisdom for his fledgling organization.... "if we always put the patients first, the profits will follow." He was more than just a little right, and his company has been richly blessed by following this credo. In this spirit, I would suggest that we best view our political persona as a PIG (Patient Interest Group).

If we truly believe in a viable future for family medicine.... if we maintain its ultimate mission as the relief of human suffering..... if we have the conviction of principle that comes with confidence in the rightness and value of our work..... and if we have the vision to see that things can always be done better then, fellow doctors, our voices WILL be heard.

This year it comes as no surprise that scope of practice issues will again be paramount in the Mississippi legislature as more and varying provider groups seek to gain what many of us glibly refer to as "another piece of the medical pie". Turf wars will certainly abound. Fur will fly. We have to make the case at every juncture that the MAFFP stands behind what is best for our patients. It is paramount that we have the legislature define and understand exactly "what is the Practice of Medicine" and quite simply who is qualified to do it. The public also needs an understanding of what is at stake here. When the time comes I think we need to get a group of medical students and residents to go to the capitol and ask the question of the Legislators, "If anyone who wants to hang out a shingle in this state can call himself a 'health care provider', then just what the heck am I doing spending 12 years of my life and going \$100,000 in debt obtaining this antiquated thing they used to call an MD degree?"

Friends, all this means that you are going to need to spend some of that commodity you hold most dear, a little of your time. Options for doing this are many. You may e-mail your representative, write a letter (yes, people still do that although it is a dying art), make some phone calls, or perhaps do what we have learned is most effective---spend some face time with those folks. A fun way to spend an otherwise bleak February day would be to volunteer to be the Doctor of the Day down at our state capitol. I hear it's a pretty incredible and totally non-stressful experience. At some point you may actually feel the old passion flowing to do the unthinkable Testify to the House of Representatives on some issue that is burning within that old ground-down psyche of yours. Four hints for when you do be truthful, be factual, be brief, and stay humble. NEVER come across as Dr. Knowitall. It cuts no dice.

Or how about marking your calendar to attend the Health issues Forum this January 11 down at the Jackson Hilton? It promises to be an interesting and informative afternoon and is always followed by a delightful and delicious reception for physicians and legislators at Dennery's Restaurant.

I hope that perhaps something I've said has ignited a spark within you to become at least marginally politically interested, and perhaps your action will follow. As always, thanks for listening.

— *Dwalia South, M.D.*

President, Mississippi Academy of Family Physicians

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Information and Quality Healthcare Payment Error Prevention Program

The Payment Error Prevention Program which began at I.Q.H. in August 1999 involves analysis of paid claims data to identify patterns of potential errors where improvement may be possible. After the identification process, the next step involves working with providers initiating interventions to prevent future errors.

One of two projects required in the PEPP effort during the first year of the contract with the Health Care Financing Administration is the identification of inappropriately coded DRGs.

The initial DRG project includes five DRGs identified through analysis of 1998 Medicare paid claims data that may represent inappropriate coding. The five DRGs include: 079 (respiratory infections and inflammations); 096 (bronchitis and asthma); 140 (angina pectoris); 182 (esophagitis, gastroenteritis and miscellaneous digestive disorders); and 416 (septicemia).

I.Q.H. staff has begun review of the records requested for the statewide DRG project. The preliminary findings reveal:

- 1) The physician-dictated reports and the physician's progress notes seem contradictory in some cases;
- 2) The ICD-9-CM codes leading to DRG assignment are not assigned as recorded by the physician, which could indicate the record is coded prior to the discharge summary being available to coders;
- 3) The physician documentation often seems vague, leading the coder to assign a code without querying the physician for clarification.

According to I.Q.H.'s senior coding specialist Joyce Shearry, RRA, who conducted workshops during the final weeks of 1999, coders cannot assign a code for a diagnosis which is not written. The responsibility of the coder is to know the coding guidelines and assign a code based on the physician documentation. On the other hand, the physician, a primary contributor in the DRG assignment maze, may not understand all the coding guidelines.

The physician can ease the DRG maze by being

more receptive to the coder when the coder requests clarification prior to assigning a DRG. This clarification must be in writing in the medical record. It is recommended that a DRG worksheet be used for such documentation or that the physician make an addendum to the record. The correct assignment of the principal diagnosis and secondary diagnoses ensures correct DRG assignment and reimbursement for facilities.

As the statewide DRG project is completed, the results of the project will be shared with the physician community to improve medical record documentation for coding purposes.

The recent DRG validation workshops were presented for acute care hospitals in the state. Ms. Shearry featured the history of DRGs, their development, how the ICD-9-CM codes lead to a DRG assignment and how the DRGs are used for case mix analysis. Participants received coding guidelines for selecting a principal diagnosis and related secondary diagnoses. Correct assignment of the diagnoses ensures correct DRG assignment and reimbursement for facilities. She emphasized that coding DRGs represents a team effort, and the team effort can help ease the DRG maze.

PEPP Video Available

The Payment Error Prevention Program (PEPP) represents the work of all the country's peer review/quality improvement organizations under Health Care Financing Administration direction. PEPP also represents a national effort to reduce the overall inpatient Prospective Payment System payment error rate and protect Medicare trust funds.

I.Q.H. is sending a copy of an introductory PEPP video to all acute care (PPS) hospitals. Produced by the Texas Medical Foundation for all PROs, the "PEPP General Introduction Video" is intended to serve as a national standardized introduction to the program. The video will inform administrative staff, compliance offic-

ers, medical staff, and other parties working with PEPP.

The video will be mailed in the next six to eight weeks to hospital utilization review departments, according to Joyce Partridge, RN, PEPP manager at I.Q.H. Questions can be directed to Ms. Partridge at 601-957-1575 or E-mail mspro.jpartrid@sdps.org.

A video on physician-medical record documentation is scheduled for release in February 2000.

Second PEPP Project

The second PEPP project identifies unnecessary admissions. Also required during the first year of the contract, this project looks at one-day stays to determine if some of these admissions could have been handled in a setting less costly to the Medicare program.

After analysis of Medicare-paid claims data for 1998, hospitals that exceeded the state average for one-day stays by more than 2.5 standard deviations were selected. Hospitals falling into this category then submit records for data collection to determine if there are opportunities for improvement.

Preliminary findings indicate that hospital admissions, according to documentation contained in the medical records, reveal a high percentage of instances where patient care could be provided in an outpatient setting or observation status rather than admission to acute care.

Dr. Ralph Dunn is medical director for the I.Q.H. Payment Error Prevention Program.

—James S. McIlwain, M.D., President

The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled, "Utilization and Quality Control Peer Review Organization for the State of Mississippi," sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content of this publication does not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

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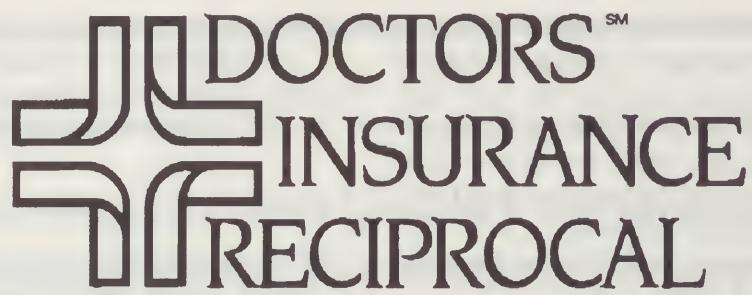
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Athenian Children by Jane Ann Lampton Moore

UMC Grad's Original Painting Graces Cover of Student *JAMA*

A UMC medical school graduate created the cover for the Sept. 1 issue of the student version of the *Journal of the American Medical Association*, or *MSJAMA*.

Dr. Jane Ann Lampton Moore, now in a family medicine residency at Duke University, was one of only seven artists whose works were selected to appear on the cover this year. She painted the watercolor reproduced on the cover during the summer following her first year of medical school.

"I was in Greece the summer of 1995 and took a photograph of the scene. I actually lay on the ground to take it because I knew immediately I wanted to paint it. The composition and color were just wonderful."

"I was with some friends from college, and we saw this small temple with those cute little girls leaning up against the temple door. I thought, 'Oh my gosh, that's beautiful.' The wonderful colors in their skirts, the shadow cast by the door- everything just came together."

The painting (*Athenian Children*) from that photograph, along with others taken from photographs made during her European tour, were displayed at the Eudora Welty Library, where the original hangs, in November, 1996. That was in her second year of medical school.

Moore, a 1999 graduate, entered the contest, designed to encourage medical students to pursue art interests throughout their professional life, as a medical student.

She admits it was difficult to find time to paint while attending medical school, but managed to squeeze it in. "Painting is so much of who I am, I had to find the time to do it."

After her show at the Welty Library, two charitable groups asked her to donate paintings for their cause, which she did. "I actually had to schedule a time to paint."

In the interest of time, she switched from oil to watercolor as a medium because it's so much quicker. One year after she was in Europe, she translated the image to a watercolor painting. "I grew to love watercolor, too, because it can take control of the painting and end up being something better than you had in mind."

JAMA comes out weekly; the *MSJAMA* comes out once a month from September through May. The oil painting on the cover of this *JOURNAL MSMA* also appeared in the November 3, 1999 *MSJAMA* issue.

Moore is the daughter of the late Dr. Ted Lampton, who was a faculty member in the School of Medicine at UMC. "He was so encouraging of our artistic pursuits. I always thought of him as an artist; he was such a wonderful story teller."

Brother Luke Lampton, a physician in Magnolia, is a writer as well as publisher of a weekly newspaper. Like her brother Luke, Moore wants to practice family medicine. "Duke is great, and the internship is good, but it's busy. Right now my paints are in the closet."

But who knows what experiences during this intense period of her life will turn up on canvas years later?

Far from viewing art as a solitary pursuit, Moore says her art depends on her interaction with people.

"You get so much from people," she said. Painting may be an act the artist performs alone, but "everything you experience and every interaction comes out in the painting."

—Janis Quinn



Dr. Arthur C. Guyton (front) is joined by the five UMC faculty members who are Billy S. Guyton Distinguished Professors, an honor named after Guyton's late father. The Guyton Professors are (from left) Dr. Ing K. Ho, Dr. Sandor Feldman, Dr. John C. Morrison, Dr. John Hall and Dr. Michael King. UMC photo by Jay Ferchaud.

Billy S. Guyton Professors Feted in UMC Ceremonies

Five nationally known faculty members from the University of Mississippi Medical Center were honored as Billy S. Guyton Distinguished Professors during ceremonies at the new Norman C. Nelson Student Union. The five were presented medallions by university Chancellor Robert C. Khayat and UMC Vice Chancellor Wallace Conerly.

"All have made significant contributions to their special field of study," Conerly said during the ceremonies last week. "All are nationally recognized as leaders in their field. They have all contributed immensely to the growth and development of this institution."

The Guyton Distinguished Professors are:

- Dr. Sandor Feldman, professor of pediatrics and director of pediatric infectious diseases.
- Dr. John Hall, the Arthur C. Guyton Professor of Physiology and Biophysics and chairman of the department.
- Dr. Ing K. Ho, professor of pharmacology and toxicology, chairman of the department and interim associate vice chancellor for research.
- Dr. Michael King, professor of neurology and anatomy as well as director of the balance and eye movement disorder laboratory.
- Dr. John C. Morrison, professor of ob-gyn and chairman of the department.

As a Guyton Distinguished Professor, each receives a \$50,000 stipend, which allocates \$10,000 per year over five years. Half may be used for a salary supplement and rest is used for research, travel or other professional development expenses.

Khayat noted that the Guyton professorships were fashioned for UMC after the Frederick A. P. Barnard Distinguished Professorships, which honored top scholars at both the Oxford and UMC campuses since 1988. In the summer of 1998, the Guyton professorships replaced the Barnard Professorships at UMC, with this being the first Guyton class of honorees.

Dr. Billy S. Guyton was dean of the medical school from 1936 through 1943 and played a critical role in UMC's development. His son, the world renowned Dr. Arthur C. Guyton, is a UMC professor emeritus of physiology and biophysics and was in the first group of Barnard honorees. Billy Guyton died in 1971.

The ceremonies were attended by UMC deans, department chairmen, directors, faculty, staff and at least three who inspired names for UMC buildings — Guyton, Dr. Blair E. Batson and Dr. Winfred L. Wiser.

All Kidney Cancers Gone After Surgeries at UMC

No cancer has returned in any of the patients who underwent the world's first renal cryosurgeries using a new interventional MRI at UMC. The revolutionary procedure destroyed cancerous tumors in the kidneys of 20 Mississippians, with the first patient treated nearly seven months ago.

"There's no sign of any cancer returning," said UMC's Dr. Patrick Sewell, who developed the procedure, performed the surgeries and is considered the world's authority on them. "That's significant. By now, we would see tumor growth, if we weren't successful."

Almost all of the kidney cancer patients who underwent the new surgery at UMC had run out of conventional medical options and, otherwise, needed to have their last remaining kidney removed - causing them to undergo kidney dialysis the rest of their lives. Instead, in the surgery at UMC, their cancer was destroyed and their kidneys and kidney functions were preserved, explained Sewell, an assistant professor of radiology.

UMC is one of three test sites in the United States for the vertical twin-magnet, interventional MRI, which makes this surgery possible. The other interventional MRIs are at Harvard and Stanford Universities' teaching hospitals.

The interventional MRI allows surgeons to see nearly "real time" video images of internal body tissue to guide them during surgical procedures. In these cases, a freezing (cryo) probe was used to destroy the cancers.

"By now," Sewell said, "if we had not destroyed all of the cancer, the tumors would have enlarged or showed other signs of being alive - and it would have shown up at one month, three months and six months." Those are the post-operative time intervals at which these patients undergo diagnostic tests to make sure no cancer is present.

In Sewell's percutaneous procedure, he froze the kidney tumors by inserting a CryoHit (surgical tube with a freezing tip at the end) through a tiny incision in the lower back. He guided the tube by following internal tissue images shown on the interventional MRI's video monitor.

MRI (magnetic resonance imaging) is to body tissue what the X-ray is to the skeletal structure. MRI provides video images of internal body tissue by using a magnetic field and radio waves to detect atoms within the body. The new interventional MRI takes technology a step further; it allows physicians to look inside patients while they perform procedures. The most obvious advantage of using the interventional MRI for this surgery is that the surgeon can instantly detect whether all of a cancerous growth is being destroyed, Sewell said.

"In these patients," he said, "this procedure is essentially a cure because we are treating their primary tumors - they had not metastasized" (spread to other parts of the body).

"This indicates the procedure, as we designed it, is very safe, very cost-effective and a very effective treatment for this type of cancer," he added. "We've done 20 people with no major complications, nor significant pain." Usually, after this surgery, the incision where the probe was inserted requires only a Band-Aid or a single suture to close it.

The 20 surgeries were performed between April 23 and Nov. 3, 1999. Sewell said every patient has gone home within a day after surgery, except one patient who stayed in the hospital for unrelated medical problems. After release, recovery time is only a few days at home.

Moreover, the kidneys apparently sustained no damage from the surgery itself. "Everybody's kidney function stayed the same as it was before surgery - and one patient's improved," Sewell said.

Dr. Bruce Shingleton, UMC assistant professor of surgery (urology), assisted Sewell in the surgeries. He pointed out that the recovery time for conventional surgery to remove a kidney is four to six weeks and it's about half that time for laparoscopic surgery that does not involve this interventional MRI procedure. Medical costs rise, of course, with more time spent in the hospital.

Patients came to UMC to undergo the new procedure because their kidneys could not be saved through conventional cancer treatment means, or because they could not "endure the physical demands of conventional surgeries, according to their doctors," Sewell explained.

Dr. Brent Harrison, UMC professor and chairman of the Department of Radiology, predicted that such successful medical results mean that the interventional MRI, or a similar machine, will be universally used within the next five years for cancer surgeries.

A native of Louisiana, Sewell also pioneered a world's-first surgical procedure called radiofrequency ablation of lung tumors, using a hot probe to destroy tumors of the lung and using an interventional CAT scanner to view the surgery in progress. At UMC and thus worldwide, that procedure only has been used on metastasized tumors (cancer that has spread). Interventional MRI cryosurgeries also have been performed at UMC to destroy liver, soft tissue, head/neck and musculoskeletal cancers. Next on the agenda are uterine fibroid tumors, prostate cancer and breast cancer.

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Cover photo: Dr. James H. Johnston, III, M.D., Jackson gastroenterologist, took this photo of a Louisiana Heron (Egretta tricolor). This dark heron with white underparts appears more slender-necked than other herons and often wades in deep water. The Louisiana Heron can be distinguished from the largest North American heron, the Great Blue Heron, by its dark head and white crown feather. The latter is reversed on the Great Blue Heron which is a largely white head and dark crown feather.

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The Impact of Zidovudine Use in HIV-Infected Pregnant Women on Vertical Transmission of HIV in Mississippi

April L. Palmer, M.D.

Hannah Gay, M.D.

Mary M. Currier, M.D.

A BSTRACT

In February 1994, results of a large placebo-controlled trial of zidovudine (ZDV) use during pregnancy (ACTG 076) showed a dramatic reduction in vertical transmission of HIV. In August 1994, the Public Health Service (PHS) recommended routine ZDV use in HIV infected pregnant women and their neonates for the prevention of vertical transmission. We retrospectively reviewed vertical transmission rates of HIV in Mississippi from 1/1/90 to 8/30/94 before the PHS guidelines were released and from 9/1/94 to 12/31/97 after the PHS guidelines were released. We also reviewed data on ZDV use in HIV infected pregnant women and their neonates from 9/1/94 to 12/31/97. Antenatal, intrapartum and neonatal ZDV use increased from 61%, 59% and 73% respectively to 79%, 77% and 92% respectively. After 9/1/94, vertical transmission rates fell by 44%. Zidovudine use during pregnancy has increased in Mississippi since release of the PHS guidelines resulting in a dramatic decline in vertical transmission rates.

KEY WORDS: HIV-1, pregnancy, Zidovudine, vertical transmission

INTRODUCTION

In February 1994, results from the pediatric aids clinical trial group protocol 076 were released. This large placebo-controlled trial demonstrated that zidovudine (ZDV) use by HIV-infected pregnant women reduced vertical transmission rates from 25.5% to 8.3%.¹ In August 1994, the Public Health Service (PHS) recommended routine ZDV use for all pregnant HIV-infected

women. This drug regimen requires oral ZDV to be started between 14-34 weeks gestation and continued throughout pregnancy, intravenous ZDV to be given during labor and oral ZDV to be given to the newborn infant starting immediately after birth and continued for 6 weeks.² After publication of the PHS guidelines, several epidemiologic studies performed throughout the US, in both urban and rural areas, have shown increased use of perinatal ZDV with subsequent declines in HIV vertical transmission.³⁻⁵ Since 9/1/94, information on ZDV vertical transmission prophylaxis for HIV-infected pregnant women has been sent from the State Department of Health to every physician in Mississippi involved in perinatal care. We sought to evaluate perinatal ZDV use in HIV-infected pregnant women in Mississippi and the possible effect on vertical HIV transmission.

MATERIALS AND METHODS

Study population. This study included pregnant women identified as HIV-infected from 1/1/90 to 12/31/97 in Mississippi and their live-born infants.

Data collection. Since 1989, active surveillance on infants born to HIV-infected women in Mississippi has been performed by the Pediatric Infectious Diseases department at the University of Mississippi and the State Department of Health, Jackson, Mississippi. Specifically, information was gathered on infants' infection status. Infants were diagnosed as HIV infected if two blood specimens were HIV DNA PCR positive with one test performed after 4 months of age or if HIV antibody was detected after 15 months of age. Infants were

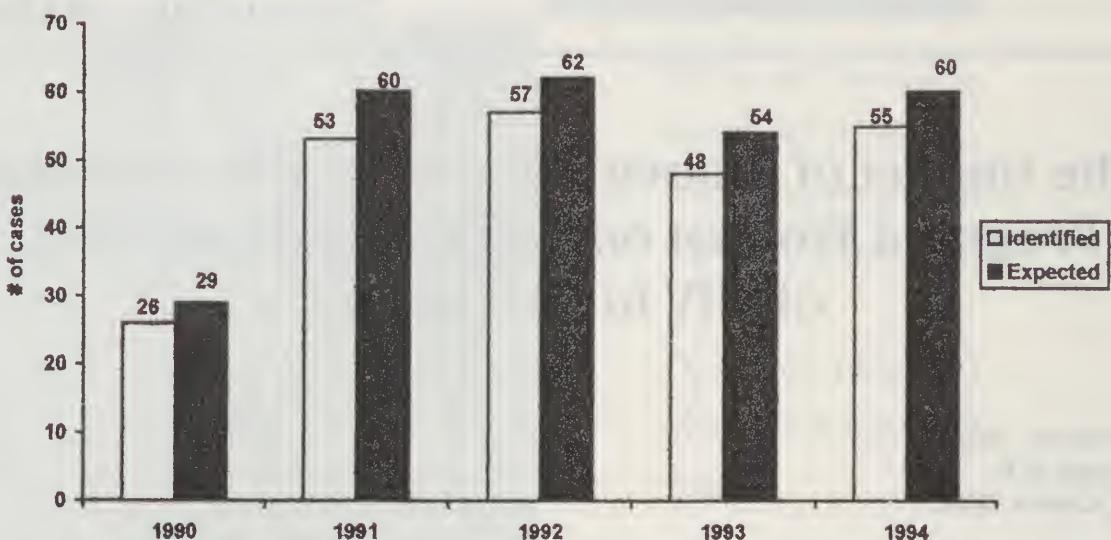


Fig 1.— Cases of perinatal HIV exposure in reported in Mississippi: Comparison to heelstick survey data

considered negative for HIV infection if two blood specimens were HIV DNA PCR negative with one test performed after 4 months of age or if an infant became seronegative. Rates of vertical transmission were calculated from 1/1/90 to 12/31/97. Information on ZDV use in Mississippi [antenatal (AN), intrapartum (IP) and neonatal (NN)] has been gathered from 9/1/94 to the present.

From 1989 to 1994, as part of the Center of Disease Control's national HIV Survey in Childbearing Women (SCBW), the State of Mississippi participated in an anonymous heelstick survey of all newborn infants. All newborns were tested for HIV antibody from residual dried filler paper spots as previously described.⁶ Rates of HIV exposed infants were then calculated and compared to reported rates.⁷⁻¹¹

Diagnostic assays. HIV DNA PCR was performed with the Roche Molecular systems assay (HIV Amplicor, Branchburg, NJ) as per manufacturer's recommendations. HIV antibody was detected with enzyme immunoassay with Western blot assay conformation in certified commercial laboratories.

Statistical analysis. Data were evaluated with χ^2 analysis where appropriate.

RESULTS

Rates of HIV exposed infants. HIV seroprevalence in pregnant women during the first 12 months the state of Mississippi participated in the SCBW was 0.9/1000 live births then steadily increased to 1.46/1000 live births by 1994 when the SCBW was concluded. Cases of reported

HIV exposed infants were comparable to the expected number of cases of HIV exposed infants as predicted by the SCBW. (Figure 1)

Adherence to the perinatal ZDV 076 protocol. Information on AN and IP ZDV use was available on 197 out of 214 (92%) and 190 out of 214 (89%) known HIV-infected pregnant women, respectively. Information on NN ZDV use was available on 202 out of 214 (94%) of the exposed newborns. Three time periods were analyzed, 9/1/94 to 8/30/95 (Period A), 9/1/95 to 8/30/96 (Period B) and 9/1/96 to 12/31/97 (Period C). Three sets of twins were born during Period C and each set was counted as one mother-infant pair. Each infant was counted separately when calculating infection rate. From Period A to Period B any ZDV use increased by 16% with the largest increase seen with NN ZDV use. AN, IP and NN ZDV use increased from Period A to Period C by 23%, 23% and 21%, respectively. Overall, any ZDV use and use of all 3 parts of the ZDV protocol increased from Period A to Period C by 16% and 27%, respectively. (Table 1 and Figure 2)

Perinatal HIV transmission rate. From 1/1/90 to 8/30/94, the period before the PHS guidelines were released, 41 out of 218 (18.8%) HIV-exposed infants were diagnosed as HIV infected. After the PHS guidelines were released, from 9/1/94 to 12/31/97, only 20 out of 197 (10%, $p=0.02$, χ^2 with Yates correction) HIV-exposed infants were diagnosed as HIV infected, a 44% reduction in perinatal transmission. (Figure 3) In mother-infant pairs where all 3 parts of the ZDV protocol were given, perinatal transmission was further reduced to 6 out

Table 1.— Adherence to the perinatal Zidovudine 076 protocol

Time period	n	Zidovudine use				Any (%)
		Antenatal (%)	Intrapartum (%)	Neonatal (%)	All 3 parts (%)	
Period A 9/1/94-8/30/95	55	31/51 (61)	29/49 (59)	38/52 (73)	24/49 (49)	42/53 (79)
Period B 9/1/95-8/30/96	70	44/62 (71)	40/63 (63)	64/67 (96)*	32/60 (53)	63/67 (94)†
Period C 9/1/96-12/31/97	89	66/84 (79)‡	60/78 (77)‡	76/83 (92)§	49/73 (67)¶	83/88 (94)§

*p=0.001 vs. Period A, Fisher exact, 2-tailed

†p=0.04 vs. Period A, χ^2 with Yates correction

‡p=0.06 vs. Period A, χ^2 with Yates correction

§p=0.01 vs. Period A, χ^2 with Yates correction

¶p=0.07 vs. Period A, χ^2 with Yates correction

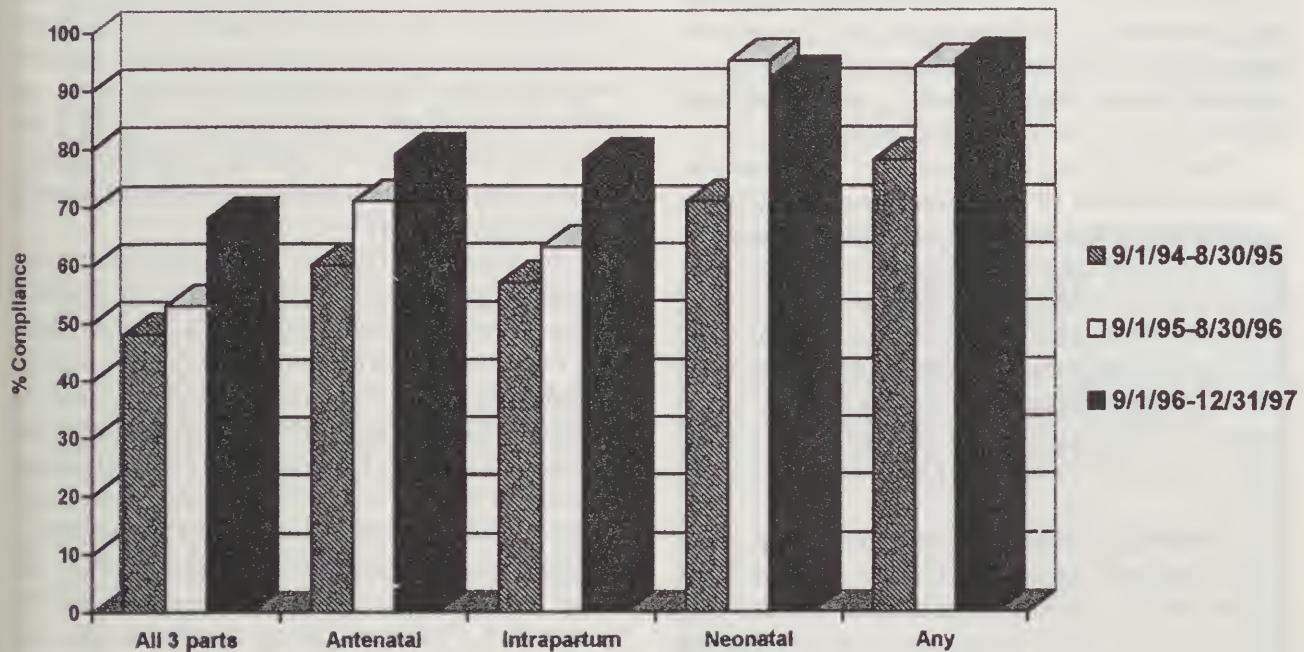


Fig 2.— Adherence to the perinatal Zidovudine 076 protocol

of 105 (6%, p=NS) HIV-exposed infants. Mother-infant pairs which had not received ZDV had a 76% higher rate of transmission than mother-infant pairs who received any ZDV (8 out of 32, 25% vs. 12 out of 188, 6%; p=0.002, χ^2 with Yates correction).

DISCUSSION

Our study shows a significant reduction in HIV vertical transmission after 9/1/94 when ZDV use in HIV-

infected pregnant women and their newborns was recommended statewide. Vertical transmission rates after implementation of the PHS guidelines, in a largely rural state such as Mississippi, are remarkably similar to the vertical transmission rates reported under ideal study conditions. Compliance to the 3-part ZDV protocol improved during the study period with concomitant falling transmission rates. The contribution of each individual part (AN, IP, NN) of the ZDV protocol to reduc-

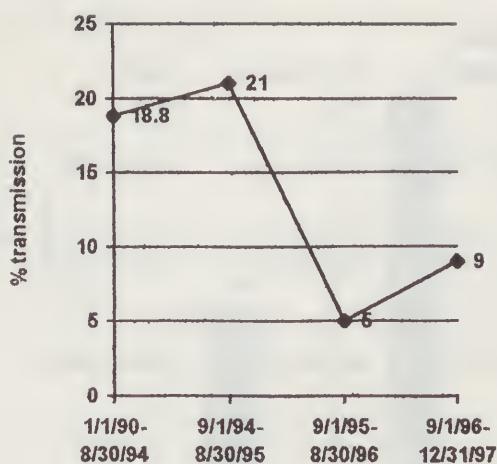


Fig 3.— Perinatal HIV transmission rate

tion of perinatal transmission is unknown. The number of woman-infant pairs who received only one of the three parts is too small to make any significant comparisons. Interestingly, the largest decline in perinatal transmission occurred between Period A and Period B when only neonatal ZDV use increased significantly.

During the time period when the SCBW was conducted, the number of identified HIV-exposed infants was similar to expected numbers of HIV-exposed infants. The limited amount of discordance between numbers of identified and expected HIV-exposed infants may be due to HIV-infected women receiving prenatal care in one state and delivering in another state, inadequate prenatal care or inadequate screening for HIV during pregnancy. Presumably, most HIV-infected pregnant women continued to be identified in Mississippi after 1994.

Maternal virologic and immunologic characteristics may influence vertical transmission rates. Previous studies have shown both maternal viral load and CD4 count to affect perinatal transmission, but only maternal viral load is consistently found to be an independent factor. Women with high viral loads are at greatest risk to transmit the HIV virus. Risk of transmission decreases with lower viral load and has been noted to be close to zero in women with undetectable viral loads.^{12,13} Too few of the women in our study had CD4 counts and viral loads performed and/or available for analysis. Therefore, we were unable to assess risk of transmission based on these maternal characteristics. Labor and delivery factors implicated as risk factors for perinatal transmission are premature birth, prolonged rupture of membranes and

invasive procedures such as fetal scalp monitoring. Reports on transmission risk differences between vaginal delivery and cesarean section have been conflicting, although a recent meta-analysis showed a decrease in transmission when cesarean section was performed prior to labor and rupture of membranes.¹⁴⁻²¹ Other than ZDV use, information on labor and delivery was limited and also not available for analysis in this study.

Current recommendations for nonpregnant HIV-infected adults stress use of combination antiretroviral therapy for maximum viral suppression in order to reduce development of viral resistance and progression to AIDS. The Public Health Service Task Force recommends that HIV-infected pregnant women receive combination therapy if their immunologic and clinical status would warrant more aggressive therapy. However, other than ZDV, limited safety data for use of other antiretrovirals during pregnancy exists. ZDV is classified as a class C FDA pregnancy risk due to animal studies which show potential toxicity. No specific human toxicity has been reported to date. HIV-infected pregnant women should be counseled about potential unknown risks to the fetus when discussing risks and benefits of starting any antiretroviral regimen. Furthermore, since ZDV is the only antiretroviral proven to prevent perinatal transmission, this drug should be part of any antiretroviral therapy used during pregnancy.²²

In Mississippi, vertical HIV transmission rates have fallen significantly since HIV-infected women have routinely been offered prenatal ZDV statewide. However, further reductions in transmission might be accomplished. All pregnant women need to be counseled about HIV testing and HIV-infected women should be offered antiretroviral therapy. However, only pregnant women who receive prenatal care will benefit. A recent CDC study on perinatal transmission showed that 74% of HIV-infected women who were not offered prenatal ZDV had little or no prenatal care. Compared to those who received prenatal care, a higher percentage of these women used illicit drugs.⁵ Health care delivery to drug-addicted HIV-infected pregnant women will require a more comprehensive approach.

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April L. Palmer is Assistant Professor of Pediatric Infectious Diseases at the University of Mississippi Medical Center, Jackson, MS.

Hannah Gay is Assistant Professor of Pediatrics and Director of the Pediatric HIV Clinic at the University of Mississippi Medical Center, Jackson, MS.

Mary Currier is the State Epidemiologist for the Mississippi State Department of Health.

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Unrestricted Riding in Pickup Truck Cargo Beds Poses Significant Hazards

Raphael C. Snead, M.D.

A BSTRACT

Individuals riding in the beds of pickup trucks face significant risks of debilitating injury or death, yet Mississippi currently has no legislation restricting ridership in truck beds. Data collection on accidents involving truck bed passengers indicates that children make up the majority of victims. Such accidents impose a heavy burden on society in terms of both medical expenses and impaired quality of life for the victims.

Key Words: pickup trucks, injury prevention, pediatric injury, lightning injury

INTRODUCTION

Over the last quarter century, significant emphasis has been placed on increasing the safety of motor vehicle occupants. Public awareness campaigns and legislation have promoted the use of safety restraints, such as seat belts and car seats, as well as air bags. However, while many safety devices have been recommended and laws have been enacted in several states regulating the placement of passengers, particularly young children, in the interiors of vehicles, less attention has been focused on passengers riding in open areas of vehicles such as pickup trucks. Due to the lack of appropriate seating or restraints in the pickup truck beds and their exposure to the environment, an

increased risk of danger to passengers in these areas would seem self-evident. Restrictions on unrestrained riding in truck beds merit renewed consideration, especially as pickups have become increasingly popular both as family vehicles and as vocational transport.

During the past three years from July 1996 to October 1999, the Children's Rehabilitation Center (CRC) of the University of Mississippi Medical Center has been involved in eight cases involving children injured in pickup truck accidents, five of whom were riding in the truck beds. Each of the five children demonstrated continuing significant impairments as outcomes of their trauma.

CASE REPORTS

A 15 year-old, African American female was riding in the bed of a pickup truck involved in a single-vehicle accident that occurred midday. She sustained a severe compression of the T-12 vertebral body with subluxation of T-11 on T-12 and a T-12 level spinal cord injury with secondary neurogenic bowel and bladder and permanent paralysis of the lower extremities. When last seen at 14 months post injury the neurological level and function had not shown significant change and she remained wheelchair bound. Length of hospital stay (LOS) was 54 days involving two separate hospitals and

Table 1— Published Reviews of Pickup Truck Bed Occupancy Accidents

Authors	Williams et al (1)	Agran et al (3)	Woodward et al (4)	Hamar et al (5)	Agran et al (6)
Year(s)	1978	1980-89	5/1986-5/1989	1983-88	1990
Source	FARS	Children's Hospital & Coroner's Office	Children's Hospital	FARS	Highway Patrol Traffic Records
Region	USA	CA (Orange Co.)	Salt Lake City, UT	Alabama	CA
# of Persons	201 (99 in pickup bed)	89 (children only study)	40 (children only study)	204	1685
Ages	0-4 2% 5-9 5% 10-14 18% 15-19 25%	0-3 19% 4-9 30% 10-14 51%	0-4 1/3 5-10 1/3 11-16 1/3	0-4 7% 5-14 29% 15-19 30%	
Total Children %	50%	NA (children only study)	NA (children only study)		66%
Location		Surfaced street 68% Highway/freeway 27% Other	Populated area 93% & paved road		Rural 43% Urban 57%
Time			0006-1800 2/3 1800-0006 1/3		0006-1800 58% 1800-0006 41%
Injury	“..sustained more severe injuries” & “had more injuries” than those in cab		Traumatic Brain Injury (TBI) 70% (30% of these major)	Cabs 35.6% killed Beds 77.8% killed	65.2% injured or killed

hospital cost from the second hospital, excluding physician fees, was \$28,463. Costs are not available from the first hospital.

An 11 year-old, African American female riding in a truck bed on a paved, rural road was struck by lightning during the late afternoon. She sustained cardiopulmonary arrest and first and second degree burns on 20% of her body surface area. She was subsequently found to have a severe hypoxic ischemic encephalopathy, coupled with spastic quadriplegia with multiple limb contractures of both upper and lower extremities and scoliosis. When last seen at 14 months post injury she still remained with severe spastic quadriplegia and a persistent vegetative state. LOS was 93 days, and hospital cost excluding physician fees was \$189,726.00.

A 7 year-old, white male who fell from the bed of a moving pickup truck was seen in consultation. Reportedly, the truck was traveling at high speed during daylight hours on a major paved highway and hit a bump, ejecting

the child, who was sitting on a mattress, from the truck bed. He sustained multiple severe soft tissue injuries, facial and orbital skull fractures, an open fracture of the left elbow and an open wound on the right knee that subsequently progressed to septic arthritis. He required plastic surgery and multiple skin grafts on both the limbs and face. He also developed a number of secondary behavioral/psychological difficulties secondary to the injury. LOS was 62 days and hospital cost, excluding physician fees, was \$103,294.

An 11 year-old, African American female fell out of the back of a truck, reportedly traveling at approximately 35-40 miles per hour, and sustained skin abrasions and lacerations, a non-displaced skull fracture and a traumatic brain injury. Although the patient displayed evidence of cognitive disability during her hospital stay, when followed up by neuropsychology at two months post injury her cognitive intellectual function appeared to be returning to normalcy. She was also found to have a

Table 2: FARS 1997 Occupant Fatalities in the Bed of Pickup Trucks (All States)

Age (Years)		Location		Month		Time	
0-6	12	Rural	108	Dec-Feb	12	0600-1200	50
7-11	13	Rural Local	39	Mar-May	30	1200-1800	51
12-15	23	Urban	37	Jun-Aug	59	1800-0000	52
16-18	27			Sept-Nov	32	0000-0600	21
19-21	11					Daylight Hours	49% (0600-1800)
>21	75						
<22	53.4%					Evening/Night Hours	51% (1800-0600)
<16	26.4%						

Modified from National Department of Transportation FARS database⁷**Table 3: Mississippi Pickup Truck Bed Accidents**

	1996 MDOT	1997 MDOT	FARS 1997 MS	1998 MDOT	FARS 1997 MS Age Fatality
Incapacitated	3	10		4	0-5 1
Moderate Injury	1	5		12	11-15 1
Complaint of Pain	1	8		1	16-18 2
No Injury	9	36		16	22 & > 2
Killed	1	1	6	1	

Modified from the Division of Public Safety Planning, Office of Highway Safety, State of Mississippi⁸

brachial plexus palsy on the left upper extremity, requiring corrective surgery at a later date and persistent neuromuscular weakness in that extremity. The CRC educator conferred with her school at five months post injury and ascertained that, although the patient's intellectual cognitive function had returned, she was showing behavior and socialization difficulties that were not present prior to the brain injury. LOS was 41 days and hospital cost, excluding physician fees, was \$61,501.

A 10 year-old, African American female fell out of the bed of a pickup backing out of a residential driveway

during daylight hours, striking her head on the concrete and sustaining a severe closed head injury. A computerized tomography head scan revealed a subdural hematoma, left frontal lobe hemorrhage, diffuse cerebral edema, and possible early transitory herniation. She underwent an emergency craniotomy for evacuation of the subdural hematoma. She also required a tracheostomy and placement of a gastrostomy tube for nutritional management. After 10 weeks she remained in a vegetative state with spastic quadriplegia. LOS was 64 days and hospital cost, excluding physician fees, was \$48,792.

Table 4: Pickup Truck Bed Occupancy

Ages Restricted & Modifiers	States with Laws Restricting
Completely Prohibited	
<18 YO	CA, NY
<16 YO	GA, MD, MO, NH
<14 YO	CT, IN, OH, OR, WI
<13 YO	
<12 YO	KS
<10 YO	MA, TX
<6 YO	NC
<5 YO	WV
Modifiers requiring some type of restraint use	FL, LA, TN
Modifiers regarding speed of truck	NM
County population modifier	MI, NM, OR, RI, WV
	MA, OH, TX
	NC

Modified from AAA Digest of Motor Laws, 1999⁹

Southeastern states bolded

DISCUSSION

In addition to these five patients, data on the injury risk of pickup truck bed occupancy described in several previous reports and studies was reviewed¹⁻⁶ and a summary of the most comprehensive medical literature is provided in Table 1. The latest available one-year data (1997) in the National Department of Transportation Fatal Accident Reporting System (FARS) database is reviewed in Table 2.⁷ In addition, separate data obtained from the Mississippi Department of Transportation (MDOT) from 1996 through 1998 is summarized in Table 3.⁸

According to the FARS data, five deaths due to riding in pickup truck beds were reported in Mississippi in 1997.⁷ One of the victims was a 10 year-old female. The others were males ranging from 20 to 45 years old. Only one of these fatal accidents occurred during the daylight hours (2:00 p.m.) and it happened on a Sunday. The other four happened between 5:00 p.m. and 10:00 p.m. Only two of the events occurred on a traditional workday, and both took place after 5:00 p.m. All occurred in rural areas. MDOT data records the death of a 26 year-old male occupant of a truck bed in April 1996. In addition, two 16 year-old truck bed passengers were involved in an accident in May 1997, resulting in one youth's death and severe, incapacitating injuries in the other.⁸

Data collection on the accidents involving those riding in pickup truck beds is based mostly on deaths and seldom includes nonfatal injuries. For example, the five accidents involving the CRC's pediatric patients were not recorded in the MDOT or FARS databases. Data collection also rarely rates the seriousness of injury or specifically distinguishes accidents involving pickup

trucks from those involving other types of motor vehicles. Even when so done, much of this data does not indicate whether the injured were riding in the truck cab or the bed. Moreover, the data from different agencies vary due to different collection criteria and differing databases. This type of data also is not readily available through the Mississippi Emergency Transport System. Thus, this data does not necessarily capture all of the serious injuries to truck bed passengers that have occurred in Mississippi during the time periods indicated.

While the different methodologies and variances in these reports limit precise inferences, review of their results does suggest some significant general findings. The overall data indicate that a significant number of injuries from these accidents occur in children. Children account for more than half of the injured in such accident cases.¹⁻⁸ One quarter to one half of these children are less than 12 years old.^{1,3,6,7}

All 50 states and DC have enacted laws requiring proper child safety restraints, though age might vary from state to state.⁹ Almost every state has some form of legislation enforcing seat belt use.⁹ However, as of this year only 22 of the 50 states, fewer than half, have enacted some form of regulations or restrictions on riding in pickup truck beds (Table 4). Only New York and California prohibit all pickup truck bed occupancy during travel.⁹ The remainder of the states with regulations generally have restrictions or modifiers either singularly or in combination with the following criteria: age, restraint use, speed of travel, or in the case of North Carolina, exemption for counties with populations under 3,500.⁹ It seems incongruous to have multiple forms of legislation and safety requirements to protect passengers of all ages in the interiors of vehicles and yet have such

piecemeal regulation of those riding in exposed areas, logically the most dangerous areas.

Although bills to regulate pickup bed occupancy have previously been introduced in the Mississippi Legislature, none have been reported favorably. There may be new or reintroduced legislation on this issue put forth in the upcoming legislative year.

Objections to legislation of pickup truck bed occupancy have been raised on several grounds. One argument states that pickup trucks are necessary in agriculture for transporting large numbers of workers, riding in both the cab and the bed, to various field locations and that general restrictions on truck bed occupancy would be an undue burden. Interestingly, none of the CRC's cases or those included in the MDOT or FARS Mississippi data occurred during agricultural or vocational activities. On the national level, while accidents of this type generally happen more frequently in rural areas, many also take place on paved streets and highways rather than unpaved roads. While many accidents happen during the daylight hours, a significant number occur in the evening or at night when one would not expect much vocational activity to be taking place. From the reports gathered, it appears that accidents involving truck bed passengers occur more often in nonagricultural areas including on paved roads, freeways and where light trucks are used more as recreational and family vehicles. To dismiss any and all restrictions on riding in truck beds because of the vehicles' role in agriculture does not address the needs of all citizens. Moreover, many state and federal agencies have regulations regarding child labor. Currently in Mississippi and under federal child labor laws, no child under 12 years of age can be employed in a vocational activity of any type.^{10,11} Children under 14 years of age cannot engage in either agricultural or nonagricultural vocational activities, with the exception of those 12 to 13 years old who are accompanied by their family in the same area of occupation and have written permission.^{10,11} Thus, the argument that riding in truck beds is necessary to agricultural activities would seem to be moot, at least in regards to restrictions on passengers under 12. For only a small number of children between 12 and 13 might the case be made that unrestrained riding in truck beds cannot be regulated. Laws regulating truck bed passengers of any age not engaged in legitimate agricultural/vocational activities could be adjusted to meet all needs and at the same time ensure all citizens' safety.

Another objection to regulation has been potential discrimination against persons in certain economic and class conditions. Some suggest that persons in lower income brackets must rely on pickup trucks for travel as

well as vocational pursuits. However, data demonstrating that certain groups purchase pickup trucks rather than enclosed vehicles out of economic pressure could not be located. Moreover, it would be discriminatory to consider any group of people less valuable or less deserving of appropriate safety regulations because of economic status, racial status or any other category. Certainly this same argument has not been proposed as a reason not to enact legislation, such as seat belt laws, that protect people riding inside enclosed vehicles.

The issue of infringing on personal freedom, also has been raised in response to proposed restrictions. If the persons injured were solely responsible for the consequences of their actions this argument might bear more weight. However, many others in society are called upon to provide both supportive and financial aid to the injured party. The rights of other members of the public must be balanced with the rights of the individual. The serious debilitating injuries suffered by our patients instill in caregivers a vested interest in encouraging greater safety requirements for the well being of all citizens. Moreover, the hefty medical costs incurred by these patients create a need to promote measures that would reduce such costs to the advantage of all citizens who ultimately pay for these expenses through insurance premiums and taxes. Society's responsibility to protect those who are too young to assume responsibility for their own decision-making, must also be considered. While parents rightly hold primacy in childcare decisions appropriate guidance is not always available to every child. Certainly children remain one of our most valuable resources. Therefore if legislation regulating all passengers in truck beds is not to be considered, then at least the protection of children should be a paramount concern.

CONCLUSION

The most dangerous area for vehicle passengers, an open truck bed, remains in many cases the least regulated and least discussed in vehicle safety education. The American Academy of Pediatrics has acknowledged specific concerns about the safety of children riding in pickup truck beds through a policy statement issued by its Committee on Injury and Poison Prevention in 1991.¹² The Academy also has made recommendations for counseling, education, vehicle development and appropriate legislation to protect children from this particular risk.¹² Restrictions on children, if not for all individuals, riding in open truck beds should be considered by appropriate law-making bodies.

Information specifically involving injuries to passengers in truck beds should be collected. These data-

bases should also include morbidity and mortality rates to create more accurate picture of the results of vehicle accidents. An additional category should include environmental factors, such as lightning strike, wind, or flying objects, that plays a role in accidents. Finally, physicians should advocate to both their patients and their legislators for further safety regulations on passengers in truck beds.

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Abbreviations:

University of Mississippi Medical Center-
Children's Rehabilitation Center (CRC)

Length of hospital stay (LOS)

National Highway Traffic Safety Administration:
Fatal Accident Reporting System (FARS)

Division of Public Safety Planning, Office of Highway Safety, State of Mississippi Department of Transportation (MDOT)

Non-applicable (NA)

States listed as U. S. Postal abbreviations

Raphael C. Sneed, M.D. is Medical Director of The Children's Rehabilitation Center, The Department of Pediatrics, University of Mississippi Medical Center, Jackson, MS. He is Board Certified in Physical Medicine & Rehabilitation and in Pediatrics.

Correspondence: R. C. Sneed, M.D.

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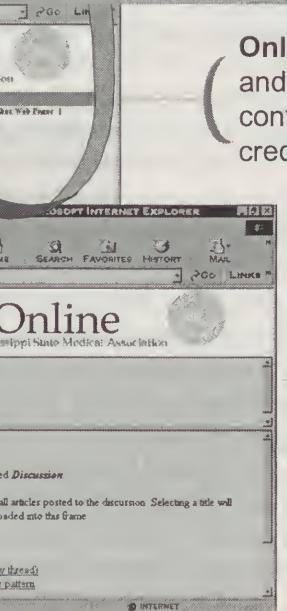
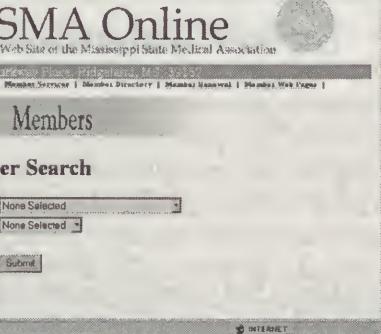
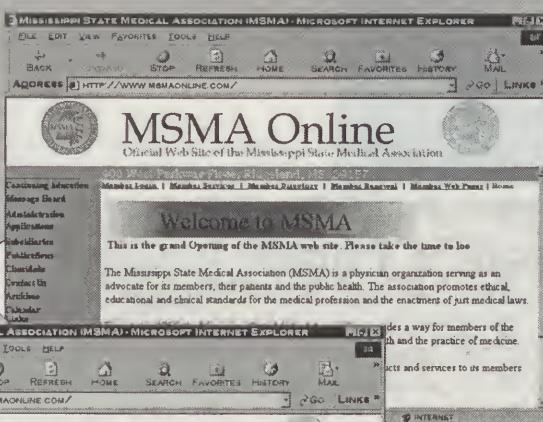


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**W. Briggs Hopson, Jr., M.D.
The President's Page**

Be My Valentine

Valentine's Day began approximately 1500 years ago in 496 A.D. when Pope Gelasius set aside February 14 to honor St. Valentine, the patron saint of love. He was martyred on February 14, 269 A.D. by Claudius II for refusing to obey him when he ordered that no marriages should be performed in Rome during his reign.

But more than honoring this martyred saint, this is the day that we let those we love touch our hearts and bind us to them. Valentine's Day has also become a symbolic day for the American Heart Association, a day when we need to pause and reflect upon the #1 killer in this country-heart disease. We as physicians realize that the heart is the motor that runs the machinery of the human body and, like all perpetual motion engines, it must be cared for properly. The heart never rests. It continues its rhythmic beat from the time it develops in the embryo until we depart this earth. We as physicians deal with it medically every day. We understand the anatomy, the pathophysiology, and the chemistry behind it. We understand the diseases that are associated with it. But how often do we stop and think on a personal basis of how we care for it. I, for one, certainly didn't until a few years ago when I found out that I had a problem with my own heart. Then, and only then, did I begin to think of the things that we need to do to keep it working as long as possible. I never thought that it really needed exercise. I never thought that it really needed the proper fuel, i.e., limited fatty intake. I never thought that it needed some rest from mental stress and strain. I never thought that it could possibly benefit from decreasing anxiety. We as physicians too often get wrapped up in the treatment of diseases with medicines that we fail to stop and realize the simple things mentioned above might help prevent the problems we see later in life.

Yes, February 14 is a date to say "I love you" to those closest to each of us but it is also a day to stop and say to your heart I love you and will try to take better care of you in the years to come. Not only will I try to take better care of you but I will also try to have all of my patients take better care of their hearts.

A handwritten signature in black ink that reads "Briggs". The signature is fluid and cursive, with a large, stylized "B" at the beginning.

Editorials

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XLI, NUMBER 2
FEBRUARY 2000

BACK TO THE AMA

In December I had the chance to attend my second AMA meeting, this time in San Diego. What a change this was from the tension of the Chicago meeting earlier in the year where furious debates raged over collective bargaining. This time there was good news. The word is out that we will have a patient protection act approved in Congress, and the political climate is such that we can almost name the provisions that we want and don't want. Then there was United Health Care's decision to end prospective and concurrent denials of coverage in order to let the attending physician have the final say. Public and AMA pressure is altering these managed care organizations in fundamental ways. And, to top that off, HCFA has produced new payments schedules for 2000 allowing us the fullest possible increases.

So the debate was milder this time, and some housekeeping measures were taken to gird the organization for coming struggles. Some of the resolutions I thought noteworthy included one calling on the AMA to push the concept that companies engaged in direct to consumer (patient) advertising have a special duty to warn of toxic effects and to provide health education about their products. Another resolution declared that use of restraints and seclusion were important enough clinical issues to warrant HCFA to use physician guidance in forming regulations on use, and that there were rights both the patients and doctors had in that circumstance. A third resolution established guidelines for physicians to report to the Department of Motor Vehicles patients with impairments affecting their ability to drive safely.

There were plenty of other resolutions, but taken as a whole these good news stories and resolutions constitute a victory for professionalism. We all know the pressure the concept of professionalism has come under in the past decades.

It is heartening to hear we can still advocate patient protections from the market and win, that United Health Care can be pushed into admitting a huge mistake, and that we can, at our own expense, get together and recommend to society how we can get impaired drivers off the roads or how to decently restrain someone for their own protection without turning them into an animal. That is, among other things, what professionalism is.

In decent societies certain fragile values are trusted to designated groups, such as physicians, teachers, journalists, and, yes, attorneys. Breakdowns in professionalism among any of these groups heralds problems for society.

It is our job to place the health of individuals and the public ahead of our other goals. When we do this we can police ourselves, work when the financial rewards aren't great, take care of poor people, and work at personal risk during epidemics. It is for this reason we have our county medical societies, our MSMA and AMA. They are some of the most important tools in striving to maintain professionalism.

—Leslie E. England, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

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This day-long skill-building experience on March 25, 2000, is by invitation only and is limited to 50 physicians. The program aims to help physicians succeed in the legislative/regulatory, organized medicine, and managed care arenas. An application, which must be postmarked by December 17, 1999, can be found on the AMA Web site at www.ama-assn.org. Participation includes complimentary registration for the NLDC and CME credit.

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JOURNAL MSMA Cover Photo Contest Winners Announced

Committee on Publications Chairman Dr. William E. Godfrey, II, *JOURNAL MSMA* Editor Dr. Leslie E. England, and Associate Editors Dr. Lucius M. Lampton and Dr. D. Stanley Hartness met in December to choose the 11 cover photographs they thought best represent the range of talent and creativity in portraying images of Mississippi. (The May *JOURNAL* cover traditionally features the incoming MSMA President's portrait.) After two and a half hours of reflection and debate, the committee selected the winning photos.

In addition to the photo of Dr. Jane Ann Lampton Moore's painting on the January cover, we plan to showcase the works of physician-photographers James H. Johnson, R. C. "Corky" Sneed, Bruce Sabatino, Mickey P. Wallace and D. Stanley Hartness on upcoming covers. You will find a brief narrative on each photograph and the photographer in the lower, left-hand corner of the table of contents in each issue.

Since 1998, when then Associate Editor Dr. Dwalia S. South introduced the clever idea, the *JOURNAL MSMA* has invited Mississippi physicians with an interest in photography to send in their best shots for a cover contest. We have been enthused with the response, receiving over 100 entries from 15 doctors across the state. This year photos of original artwork are also included.

The task of selecting the final photos to be featured is somewhat overwhelming. Entries of subjects indicative of Mississippi and vertical formats take precedence in consideration.

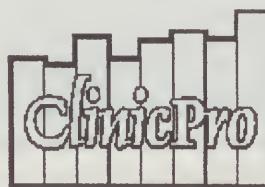
We hope other physician-photographers will enter next year's contest and those who submitted entries which were not selected will resubmit entries. Photos not selected this year will automatically be reconsidered for next year's covers unless the entry is requested to be returned. Should you wish to have your work returned you may contact Managing Editor Karen Evers, phone: (601)853-6733, extension 323 or 1-800-898-0251.

In other business, the committee considered updating the *JOURNAL MSMA* nameplate. The old flag ap-

peared antiquated because it incorporated an early MSMA logo. They looked at several more contemporary designs but after careful consideration decided our *JOURNAL* flag has classic appeal easily distinguished from other medical journals and updated the nameplate using the current logo for the letter "o". You will note minor modifications in this and future year 2000 issues. And, watch for some new feature departments as well.

Remember, this is YOUR Journal. Your input and ideas are encouraged. Send me your letters. Submit your scientific articles. Take time to voice your opinions and use the magazine as the communication tool it is meant to be.

—Karen A. Evers
Managing Editor



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Southern Medical Association Auxiliary

SMA Auxiliary and MSMA Alliance News



Merrell Rogers (Mrs. Lee) was installed as president of the Southern Medical Association Auxiliary for 1999-2000. Her installation service was conducted by Jean Hill.

The 1999 Annual Session of Southern Medical Association (SMA) and Auxiliary, held in Dallas, Texas, was a success for the Mississippi State Medical Association Alliance. Merrell Rogers (Mrs. Lee) was installed as president of the Auxiliary for 1999-2000, and the Mississippi State Medical Association Alliance received five awards for its work in Health Education, as well as for Doctors' Day, and Medical Heritage.

Peggy Crawford (Mrs. Dewitt) accepted the Best State Project award in Health Education. The project for 1999 was BATTLE (Breast Cancer Awareness To Teach Ladies Early Detection) and was a partnership with the MSMA and MSMA Alliance, the Mississippi Academy for Family Physicians, and the Mississippi Extension Service. Martha Clippinger (Mrs. David) received the first place award for a state project in the category of Medical Heritage. Lee County Medical Alliance won first

place in the category of Alliances over 75 members for its work in Doctors' Day. Susan Rish (Mrs. James) accepted for her Alliance chapter. Mary Helen Schaeffer (Mrs. Phillip), President of the MSMA Alliance, accepted the award for North Central Medical Alliance for its project in BATTLE. This was awarded to Alliances under 75 members. Jones County Medical Alliance WOW project won the first place award for Doctors' Day in the category of under 75 members.

Merrell Rogers took the honors in the Auxiliary for securing the largest number of new members for the past year.

This was the 75th Anniversary Celebration for the Auxiliary. The Session was filled with varied activities because of the Celebration. Numerous hours of continuing medical education were available to the physicians. Evening activities included a rodeo at the Mesquite Arena,

a reception at The DeGolyer House at the Dallas Arboretum and Botanical Garden, and a reception for Merrell at the Anatole Hotel. Enrichment programs included History and Glitz, the Georgia O'Keefe Exhibit and Arboretum, a tour of Grapevine, and a day of shopping at the Dallas Designers' Factory.

Dr. William J. Bennett, author of *The Book of Virtues* and *The Children's Book of Virtues*, was the guest speaker for the Presidents Doctors' Day Awards Luncheon and "Ethics for the New Millennium" Symposium.

Southern Medical Association and Auxiliary are composed of 16 states and the District of Columbia. Please call 800-423-4992 to receive information for joining SMA. The 94th Annual Scientific Assembly will be in Orlando, Florida, November 1-4, 2000. — *Peggy Crawford*



Drs. Dewitt G. Crawford, John M. Estess, and J. Edward Hill proved physicians are versatile. They were waiters at this reception.



The Mississippi delegation dressed for the rodeo at the Mesquite Arena.



Hart Rogers, Ray Reed Jr., M.D., Susan Rish, Kim Reed, and James Rish, M.D. enjoy the fellowship and activities provided by SMA and Mississippi.



Peggy Crawford and Louis Cancellaro, M.D., Past President of SMA, listen to James C. Waites, M.D., Special Advisor to the Auxiliary, share his expertise with Ronald C. Hamdy, M.D., President of SMA.

“To Err is Human”—or Is It Process?

A number of national news stories in recent months have focused attention on medication errors. The fact that medication errors can occur in the course of providing care has long been recognized. Of course, the medication management system does not have one specific owner. The core processes involve physicians, nurse practitioners, CRNAs, RNs, LPNs, pharmacists, and respiratory therapists, as well as other team members who are a part of the process.

Billions of medication dosages are administered each year. An incident often occurs before the health care community takes preventive action. An average error rate greater than that allowed the postal system or air traffic control seems to be tolerated.

A medication error is defined as any unintended act in the process of ordering, dispensing, or administering a drug. An adverse drug event is an injury related to the use of a drug which may or may not be due to an error. Most errors do not result in an adverse outcome; however, the costs of adverse drug events are significant. Studies have documented increased costs associated with length of stay and delivery of services (excludes liability costs or costs of injuries) as well as increased mortality risk. Injuries resulting from drug utilization affect as many as 1.5 million hospital patients annually.

Some studies have shown that approximately 95% of drug errors are unreported. Health care providers tend to look for someone to blame when an error occurs rather than looking at the error from a “systems” perspective. Because punishment is feared, reporting of errors is inhibited. Certainly people do not make errors on purpose. It should be recognized that most errors occur because of systems (process) problems, not people problems. The most powerful method for reducing risk of errors is to simplify the system: review the steps in the medication management process.

A critical point has been reached with an urgent

cause. Although many aspects of health care delivery are vulnerable to human error, several studies have documented that medication errors are the most frequently occurring patient-adverse event. Reviews of relevant literature reveal that leaders in the field of pharmacology and quality assurance consistently urge health care providers to acknowledge the existence and importance of medication errors and to make a commitment to develop initiatives to improve the delivery of pharmacological agents to the public. Such an effort requires a systems approach and involvement of a wide range of health professionals including physicians, pharmacists, nurses, drug product manufacturers, government agencies, accrediting entities, and patients/ families.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) identified medication use as a priority for 1999. It was expected that a significant number of health care organizations would receive Type I contingencies and random unannounced surveys related to medication use. Standards related to medication use caused 23% of the Type I contingencies for Mississippi hospitals.

The time has arrived to reduce medication errors through utilization of continuous quality improvement principles. The health care model which is used to promote continuous improvement in a patient’s condition can promote continuous improvement in healthcare delivery processes for a patient-centered approach to care. Educated to be critical thinkers and problem solvers, by working together, everyone on the team can assess, plan, intervene, and evaluate for improving the medication management process for the benefit of all healthcare consumers.

—Denise Autonberry, PhD, RN

Dr. Autonberry serves as the corporate vice-president of I.Q.H.

Personals

Michael E. Jabaley, MD, FACS visited Guadalajara, Mexico in early December as Honored Professor of the Jalisco Institute for Reconstructive Plastic Surgery and the Western Society of Plastic and Reconstructive Surgery. Dr. Jabaley spoke on five aspects of hand surgery involving nerve, fracture, arthritis, and carpal tunnel syndrome. In addition, he performed surgical demonstrations at the Jalisco Institute, a charity hospital founded by respected plastic surgeon Jose' Guerrerosantos. Dr. Jabaley is president of Plastic Surgery Associates, P.A. and is Clinical Professor of Plastic and Orthopaedic Surgery at the University of Mississippi School of Medicine and past chairman of the Division of Plastic Surgery at the University Medical Center (UMC). He

has practiced plastic and reconstructive surgery for over 30 years. Dr. Jabaley is an active member of the American Society of Plastic Surgeons and is past president of the American Society for Surgery of the Hand, the American Association of Plastic Surgeons, The Sunderland Society, and the Mississippi Chapter of the American College of Surgeons. He received his medical degree from Johns Hopkins School of Medicine and completed residencies at Johns Hopkins and Massachusetts General Hospital. He was Professor of Plastic Surgery at Johns Hopkins and served in the United States Army Medical Corps in Vietnam.

Tom Herrin, M.D. is now Medical Director at St. Dominic-Jackson Memorial Hospital, Jackson,

Mississippi. Dr. Herrin is well known to St. Dominic's and was a member of St. Dominic's medical staff from 1981 to 1998. Dr. Herrin earned his undergraduate degree from the University of Southern Mississippi and his medical degree from the University of Mississippi. He completed his anesthesia residency at the University of Texas Medical Branch in Galveston, Texas, and is a Board Certified Anesthesiologist. Dr. Herrin has held academic appointments at the University of Texas Medical Branch, Baylor College of Medicine and the University of Mississippi. Throughout his career, Dr. Herrin been active in professional and civic organizations. He has held many national appointments in the American Heart Association and is Chairman of the Council of

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Advisors for Respiratory Care Practitioners at the Mississippi State Department of Health. Dr. Herrin has also been active in the Boy Scouts of America, receiving numerous awards for his involvement. He currently serves on the District Advancement Committee for Eagle Scouts.

Barry Whites, M.D., of Jackson, and **Clark G. Warden, MD, FACS**, of Pascagoula, recently received three-year appointments as Cancer Liaison Physicians for the Hospital Cancer Programs at Rankin Medical Center and Singing River Hospital, respectively. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons. Drs. Whites and Warden are among a national network of over 1,800 volunteer Cancer Liaison Physicians who provide leadership and support to the

Approvals Program, and other Commission on Cancer activities. Both have a significant interest in the diagnosis and treatment of patients with malignant diseases and provide leadership to the cancer committee at their appointed institutions in order to maintain their Commission-approved cancer program, or assist them in seeking approval as a new program. They also provide community leadership by volunteering at the division or unit level of the American Cancer Society.

Jeff Clark, M.D. was recently honored by being elected to the American College of Surgeons. Dr. Clark received his medical degree from the University of Alabama School of Medicine and his residency in Surgery and Urology at The University of Mississippi Medical Center. He practices Urology at Brookhaven Urology Clinic.

He is also a Diplomate of the American Board of Urology.

Gene R. Barrett, M.D., one of the founding partners of Mississippi Sports Medicine and Orthopaedic Center in Jackson, recently was selected for membership to The American Orthopaedic Association (AOA). The AOA is the oldest English speaking orthopaedic organization and one of the most prestigious. Currently, there are only three other practicing physicians in the state of Mississippi who are members of the AOA. In order for a physician to become a member, he must be nominated by a member and be voted in by the members at the annual meeting. He also is required to have made a significant contribution to education, research, and the practice of orthopaedic surgery. Dr. Barrett will attend the annual meeting next June where he will be officially in-

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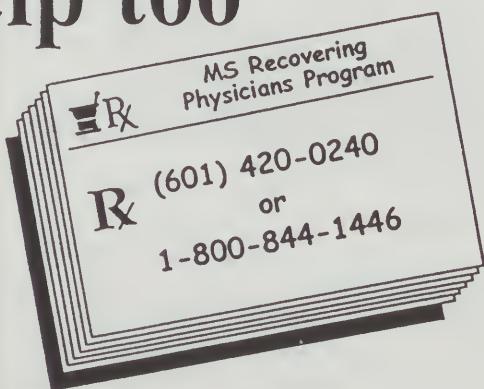
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ducted into the society. Dr. Barrett was also elected to the Chairmanship of the Hughston Sports Medicine Society. This society is made up of all orthopedic surgeons that trained with Sports Medicine and Knee Surgery pioneer, Dr. Jack Hughston.

Larry D. Field, M.D. recently participated as a Faculty Member at the Orthopaedic Learning Center in Chicago, Illinois. The meeting was sponsored by the Arthroscopy Association of North America and was entitled "Advanced Arthroscopic Techniques in Shoulder Surgery."

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Leola Meyer (Ext.5487)



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Gulfport, MS 39502

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Jackson, MS 39204

Biloxi Regional Medical Center
150 Reynoir St.
Biloxi, MS 39530

Mississippi Baptist Medical Center
1225 N. State St.
Jackson, MS 39202

Council on Scientific Assembly
MS State Medical Association
408 West Parkway Place
Ridgeland, MS 39158

MS State Department of Health/
MS Association of Public Health Physicians
P. O. Box 1700
Jackson, MS 39215

Delta Regional Medical Center
1400 E. Union St.
Greenville, MS 38704

Natchez Regional Medical Center
54 Sergeant S. Prentiss Dr.
Natchez, MS 39215

Forrest General Hospital
Mamie Street & Highway 49 South
Hattiesburg, MS 39404

North Mississippi Medical Center
830 S. Gloster St.
Tupelo, MS 38801

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Greenwood, MS 38930

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1970 Hospital Dr.
Clarksdale, MS 38614

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Grenada, MS 38901

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Meridian, MS 39301

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Meridian, MS 39301

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2809 Denny Ave.
Pascagoula, MS 39581

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**The MSMA Legislative Report 601-853-6733
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Published weekly during each annual session of the Mississippi Legislature, this informative newsletter provides association members with the latest news on legislative and political events. It also keeps members abreast of health legislation that is under consideration and the association's position on hundreds of health-related bills.

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**Legislative Forum 601-853-6733
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**Annual Meeting 601-853-6733
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**MSMA Website 601-853-6733
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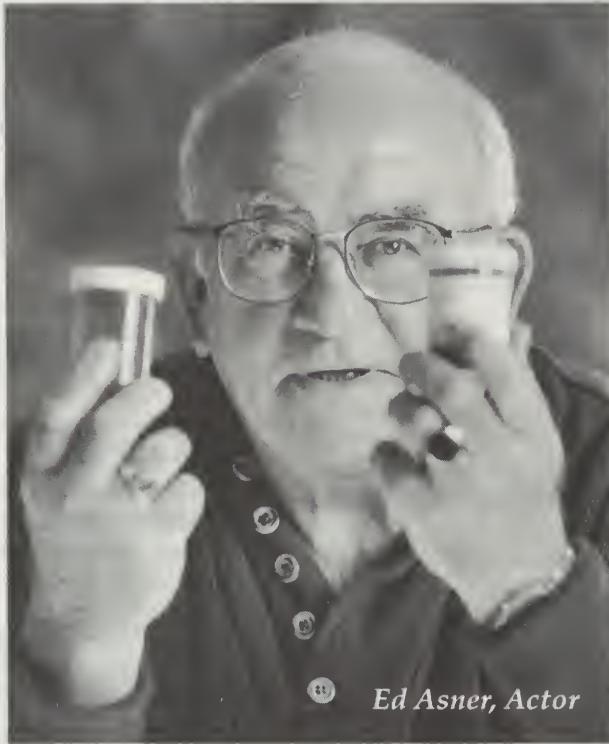
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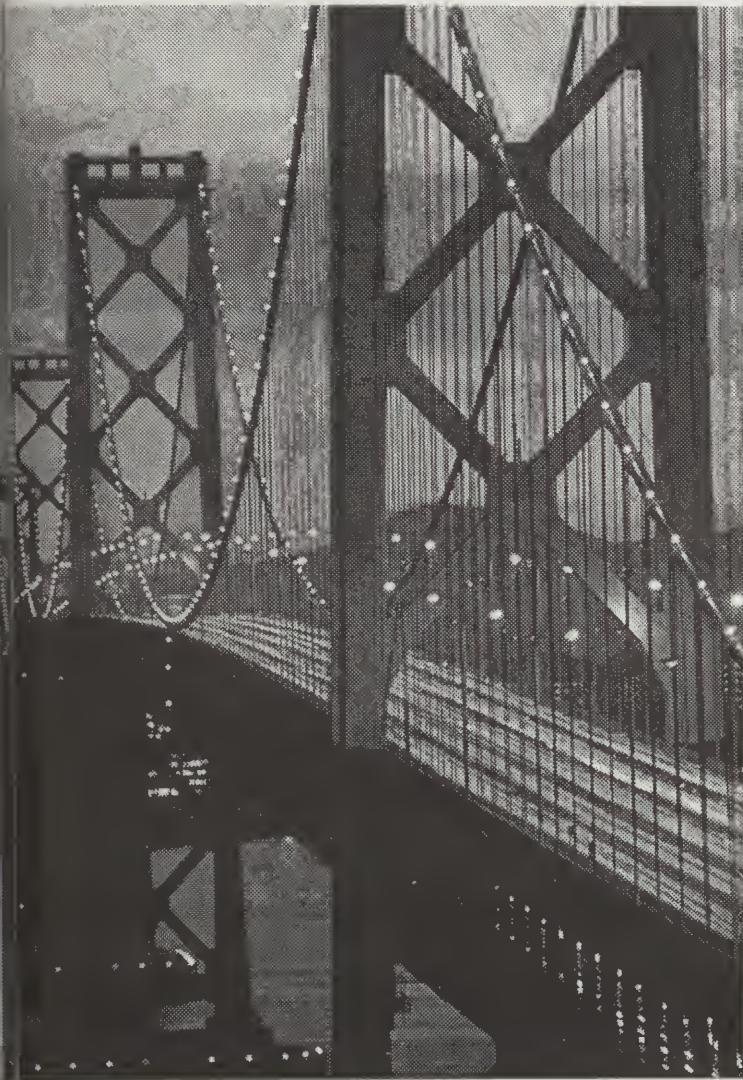
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JOURNAL MSMA
Managing Editor: Karen A. Evers
408 West Parkway Place,
Ridgeland, MS 39157
P.O. Box 2548,
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(601)853-6733,
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Primary Hypothyroidism Presenting As A Pituitary Mass

William C. Nicholas, M.D.
William F. Russell, M.D.

A bstract

Pituitary enlargement secondary to primary hypothyroidism is a known but uncommon occurrence, which can be difficult to distinguish on computerized tomography (CT) and magnetic resonance imaging (MRI) from primary pituitary tumors.

We describe a 33 year old female who was referred to a neurosurgeon for removal of a pituitary mass. The markedly elevated thyrotrophin stimulating hormone (TSH), absence of clinical features of hyperthyroidism, and low thyroid hormone values led to a diagnosis of pituitary enlargement secondary to primary hypothyroidism.

The pituitary gland returned to normal size with thyroxine replacement therapy. Surgery was not indicated.

KEY WORDS

Pituitary Mass
Hypothyroidism
Elevated TSH

PRIMARY HYPOTHYROIDISM PRESENTING AS A PITUITARY MASS

Primary hypothyroidism can lead to sella turcica enlargement, as well as enlargement of the pituitary gland. It has also been known that the volume of the sella turcica shows a direct relationship as to whether the patient may have primary hypothyroidism or hyperthyroidism, with the volume of the sella turcica being increased in the former and of normal size in the latter.¹ With the advent of computer tomography and magnetic resonance imaging, it

has been increasingly important for physicians to be aware that pituitary enlargement may not be associated with primary pituitary tumors but, in fact, could be related to target organ failure. This report describes a patient who was thought to have a pituitary tumor but, following evaluation, was found to have primary hypothyroidism. There was complete remission of the pituitary enlargement and of the patient's symptoms with thyroxine therapy.

A 33-year-old female patient presented to her local physician with the main problems of tiredness, amenorrhea, and galactorrhea, which had persisted for two years following discontinuation of the nursing of her child. Investigation revealed a prolactin level of 114 ng/ml (N = 1.3-24.2 ng/ml), a thyroxine of less than 1.0 mcg/dl (N = 4.5 - 12.5 mcg/dl), and a TSH concentration of 677 mcu/ml (N = 0.4 - 5.5 mcu/ml). These results prompted a MRI pituitary scan, which revealed pronounced enlargement of the pituitary gland displacing the optic chiasma superiorly. At that point, the patient was referred to a neurosurgeon for removal of the tumor.

The patient stated that she was well until the birth of her fifth child in December 1993 following which she breastfed the baby for two years. During that time, she had no menses and felt well. Her weight was approximately 135 lbs. She gained approximately 30 lbs. slowly over the next three years. She noticed some decrease in energy, slight cold intolerance, and her skin was drier than usual. After she discontinued breastfeeding in 1995, the galactorrhea persisted to a

minor degree and her menstrual periods did not recur.

Physical exam revealed the patient to be a good historian, in no apparent distress. Her face appeared puffy and pale. The visual fields were normal on confrontation. There was no palpable thyroid tissue. On breast exam, milk could be expressed from each breast. Her heart rate was 72 and regular. The reflexes revealed delay in relaxation for both the upper and lower extremities. The skin was dry with some puffiness of the hands and the lateral third of the eyebrows did appear to be sparse.

Laboratory investigation revealed negative anti-thyroid microsomal antibodies, afternoon serum cortisol was 7.9 $\mu\text{g}/\text{dl}$ ($N = 2.0 - 9.0 \mu\text{g}/\text{dl}$), and another TSH done prior to being seen was 989 $\mu\text{cu}/\text{ml}$.

A diagnosis of primary hypothyroidism with secondary pituitary enlargement was established. The patient was referred to neuro-ophthalmology for assessment, which revealed no visual field abnormalities. The patient was begun on thyroxine therapy, commencing on

a dose of 0.05mg daily and increased to a total dose of 0.125mg daily. A repeat MRI of the pituitary fossa six weeks after commencement of thyroid therapy revealed approximately 50% regression of the pituitary size. The TSH had decreased to 1.46 $\mu\text{cu}/\text{ml}$ ($N = 0.23 - 4.0 \mu\text{cu}/\text{ml}$) with a free T4 of 1.24 ng/dl ($N = 0.6 - 1.6 \text{ng}/\text{dl}$). Another MRI of the pituitary fossa undertaken four months following therapy revealed complete remission of the pituitary enlargement. (Figure 1) The patient was euthyroid with a TSH of 1.46 $\mu\text{cu}/\text{ml}$ and her original symptoms resolved.

DISCUSSION

It has been known for almost 150 years that the pituitary gland enlarges with hypothyroidism. This was described in 1851 (Niepce) in autopsies done on patients who died with cretinism.² The sella turcica also enlarges in patients with primary hypothyroidism (Yamada).¹ This study, involving euthyroid, hypothyroid, and hyperthyroid patients, revealed that the sella turcica on three

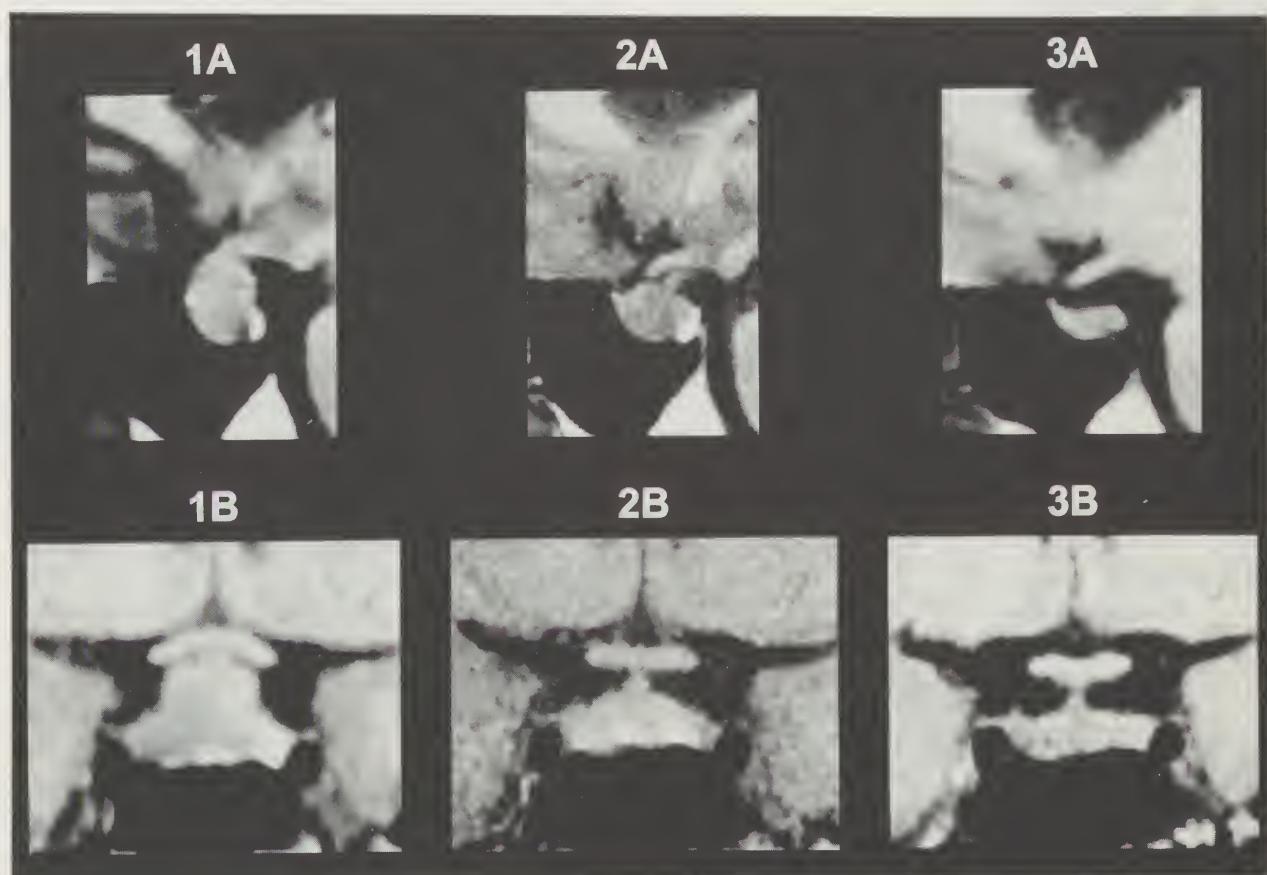


Fig 1.— Top Row: Sagittal T-1 weighted MRI without contrast. Bottom Row: Coronal Plane T-1 weighted MRI without contrast. 1-a,b Pre-treatment MRI at presentation shows marked, homogeneous pituitary gland enlargement extending into the suprasellar cistern and elevating the optic chiasm.

2-a,b Repeat MRI 6 weeks after treatment shows 50% reduction in size of pituitary gland.

3-a,b Follow-up scan 16 weeks post-treatment. Patient is euthyroid by lab and pituitary has now regressed to its normal size and position.

dimensional measurements was increased in size in 81% of patients with primary hypothyroidism. The magnitude of the increase was inversely related to a decrease in the serum thyroxine and was directly related to an increase in circulating TSH. Furthermore, it has been shown that destruction of the thyroid gland in animals, particularly the mouse, led to pituitary hyperplasia with the eventual development of pituitary adenoma (Moore).³

In humans, enlargement of the pituitary becomes manifest only when there is an increase in its size or destruction of the sella turcica takes place. The pituitary gland normally occupies about 80% of the pituitary fossa and studies have shown that it has to increase to 125% of its normal volume before significant abnormalities can be detected (Dichiro).⁴ In the review of the literature by Beck-Peccoz, they found CT or MRI abnormalities in 59% of 100 patients with primary hypothyroidism.⁵ The commonest pituitary hormone abnormality associated with TSH-secreting pituitary tumors, is that of hyperprolactinemia. Hypothyroid patients with hyperprolactinemia are more likely to have pituitary tumors and they are also more likely to be larger than those with isolated TSH elevation (Thomas).⁶

Thyrotrope hyperplasia is the rule rather than the exception in primary hypothyroidism shown by a study of 64 hypothyroid patients. Almost all of these patients had either diffuse or nodular thyrotroph hyperplasia and, in some instances, had what was thought to be true adenomas.⁷ It is not known why some patients develop severe forms of pituitary hyperplasia while others develop adenoma, some of which are not suppressed by thyroid therapy. The pituitary enlargement that occurs following some cases of primary hypothyroidism has also led to deficiency of other pituitary hormones and anterior pituitary failure (Vagenakis).⁸

In our patient, it would appear that the hypothyroidism came on slowly following delivery of her last baby making the most likely diagnosis post-partum thyroiditis. This etiology was seen in 4% of patients described in the Beck-Peccoz excellent review.⁵ In this review of hypothyroid patients presenting with pituitary hyperplasia, the mean TSH was 289 ± 37 mcu/L with the mean prolactin being 62 ± 7 mcg/L. Elevated prolactin, as seen in our patient, is well recognized in primary hypothyroidism with or without pituitary enlargement but the levels usually do not reach those seen in pituitary prolactinomas. Anti-thyroid antibodies in their series were positive in more than 75% whereas, in our patient, these microsomal antibodies were negative.

A pituitary mass associated with marked elevation of TSH in the presence of clinical hypothyroidism should

alert one to the diagnosis of primary hypothyroidism with secondary pituitary hyperplasia. Pituitary masses with excess TSH should, in fact, produce a hyperthyroid clinical situation (Beck-Peccoz).⁵

Our patient's amenorrhea could have been related to the primary hypothyroid state, or pressure effect from the pituitary hyperplasia. The latter would be supported by her very low luteinizing hormone level of 0.3 miu/ml (N = 0.6 – 105). The follicle stimulating hormone, however, was normal at 8.2 miu/ml (N = 1.0 – 26.0). It is known that failure of target organs, such as the thyroid and ovaries, can lead to pituitary enlargement and abnormal sella turcica (Danzinger).⁹ Computerized tomography and magnetic resonance imaging have allowed us to diagnose and follow these pituitary abnormalities with much more accuracy than in the past. A recent article revealed dramatic shrinkage on MRI of a pituitary mass within one week of thyroid hormone therapy (Sarlis).¹⁰

Therapy is replacement with physiological thyroxine doses. This will lead to regression of the thyroid clinical symptoms. However, as shown in the review by Beck-Peccoz⁵ et al in their study of both adults and children, total regression of the pituitary lesion occurred in only 62% and partial regression in 29% of the patients. In those patients where pituitary size did not regress, it is difficult to know whether they may be one of the patients with incidentaloma of the pituitary, which is not uncommon as shown by autopsy studies.¹¹

CONCLUSION

In conclusion, one must be vigilant to the fact that, although pituitary tumors can lead to hypothyroidism, they also can be secondary to thyroid failure. The differential can readily be made by proper interpretation of the basic thyroid test.

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William C. Nicholas, M.D. is Associate Professor,
Department of Medicine in the Division of
General Internal Medicine and

William F. Russell, M.D. is Professor, Department
of Radiology, both at the University of Mississippi
Medical Center.

Reprint Requests: William C. Nicholas, M.D.
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Sonographic Measurements of Fetal Parts to Predict Pulmonary Maturity Among Twins and Singletons

Suneet P. Chauhan, M.D., et. al

A

bstract

To determine if sonographic examination of fetus can be readily utilized to predict a mature lecithin/sphingomyelin (L/S) ratio among twins and singletons. Twins ($n=36$) undergoing amniocentesis for assessment of pulmonary maturity were matched with singleton (1:2) for maternal demographics, gestational age (GA), and indications for procedure. At the time of amniocentesis, twins and singletons with mature L/S ratios differed significantly in mean GA (33.2 ± 2.7 vs 34.5 ± 4.6 wks, $p = 0.01$), biparietal diameter (BPD), abdominal circumference (AC), femur length (FL) and estimate of birth weight (EFW). Based on ten receiver operating characteristics curves constructed, the following diagnostic thresholds predicted a mature L/S ratio with a true positive rate of 100% among twins and singletons, respectively: 1) BPD $\$ 84$ and $\$ 92$ mm; 2) head circumference $\$ 315$ and $\$ 320$ mm; 3) AC $\$ 295$ and $\$ 350$ mm; or 4) FL $\$ 64$ and $\$ 72$ mm; or 5) EFW $\$ 2400$ and $\$ 3200$ g. Using any one of these five criteria correctly identified pulmonary maturity among 59% of twins and 28% of singletons ($p = 0.001$). Sonographic measurement of fetal parts or EFW may be a noninvasive method to predict a mature L/S ratio among twins as well as singletons.

Introduction

Assessment of pulmonary maturity before 36 weeks' gestation is an important issue for twin pregnancies, as they experience greater risk for preterm delivery,¹ premature rupture of membranes,² and discordant pulmonary maturation. Previous studies of the lecithin/sphingomyelin (L/S) ratio in multifetal pregnancy³⁻⁷ indicate that fetal lung maturity often occurs at an earlier gestational age with twins than singletons.⁵ While the L/S ratios of both twins may be similar,³⁻⁷ it is also possible that they may be discordant. Leveno, et al⁵ noted in 11% (5/42) of twins undergoing concurrent amniocentesis, that one fetus had a L/S ratio > 2.0 and the other did not. Although the most precise assessment of lung maturity of diamniotic twins would require amniocentesis of each sac, this invasive procedure has potential complications. Therefore, it would be ideal and beneficial to have a reliable noninvasive means to assess fetal lung maturity in twin gestation.

Published work on singleton gestations indicates that sonographic mensuration of fetal parts may accurately predict the presence or absence of neonatal hyaline membrane disease.^{7,8} Golde, et al⁸ reported that a

biparietal diameter (BPD) ≥ 9.2 cm was associated with L/S ratio > 2.0 in 93% and absence of respiratory distress syndrome in 100% of cases. Petrucha, et al⁹ confirmed these findings for singletons, noting that among four twin pregnancies, the relationship between BPD and pulmonary maturity was also valid. These data were too limited to be helpful in the prediction of fetal lung maturity for multiple gestation and lacked the availability of concurrent determination of L/S ratios for each twin.

The goals of this prospective study were to determine if there is a significant difference in the timing of pulmonary maturation of twins as compared to singletons and to determine if sonographic mensuration of fetal parts or estimate of birth weight could serve as reliable surrogate measures of pulmonary.

Materials and Methods

During a two year period, all diamniotic twins pregnancies who underwent amniocentesis of both sacs to assess pulmonary maturity were included in the analysis. In every case, standard sonographic measurements of fetal parts—BPD, femur length (FL), head circumference and abdominal circumference (HC and AC, respectively)—were obtained prior to the procedure. Estimate of fetal weight was derived from the formula proposed by Hadlock et al, which utilizes BPD and AC to predict the birth weight.¹⁰ The ultrasonographic examinations were performed with a linear 3.5 MHz transducer on an Ultramark IV ultrasound unit (Advanced Technology Laboratories, Bothell, WA). The exclusion criteria were twin gestation with known anomalies, demise of one of the fetuses, inability to obtain amniotic fluid from both gestational sacs, and medical or obstetric complications, such as insulin requiring diabetes, chronic hypertension and isoimmunization. The matched cohort consisted of the next singleton, studied in sequence, with similar maternal ethnicity, gestational age at amniocentesis, and obstetric indication for the procedure.

Amniotic fluid L/S ratios were determined by thin layer chromatography on the day of specimen collection.¹¹ An L/S ratio of $\geq 2.2:1$ is considered mature at this laboratory.

Statistical tests included the Student t-test, chi-square analysis or Fisher exact test where appropriate. A p value < 0.05 was considered significant. The relative risk (RR) and 95% confidence interval (CI) were determined for contingency data. Ten receiver-operating characteristics (ROC) curves were generated for BPD, HC, AC, FL and sonographic estimate of birth weight to predict a L/S ratio of 2.2, among twins and singletons. These curves were developed by plotting the sensitivity

(true positive rate) against 1 - specificity (false positive rate) for a given biometric measurement to predict pulmonary maturity. The area under the curve (w) and the standard error (SE) were estimated by point-to-point trapezoidal method of integration. The critical ratio z test for a paired statistical design was used to determine statistical significance of the curve.¹²

Results

During the two year period there were 36 sets of twins which met the inclusion criteria and they were compared to 72 singletons. Table I shows that maternal demographics and test indications were similar in the twin and singleton groups. The mean (\pm standard deviation) L/S ratio for singleton gestations was 3.9 ± 3.0 , and for twin A and B, it was 5.2 ± 2.8 and 5.0 ± 2.7 , respectively. Ten twins and 26 singletons had L/S ratios < 2.2 ($p = 0.05$; RR 0.55, 95% CI 0.3 - 1.0). The incidence of discordant pulmonary maturity was 5.5% (2/36 twin pairs). In one case the L/S ratio for the two fetuses were 4.5 and 1.9, and in the other, 1.3 and 2.2.

Table II is a comparison of the gestational age (GA), sonographic measurements of fetal parts, and estimate of fetal weight (SEFW) among twins and singletons with pulmonary maturity. The ROC curves for fetal parts and SEFW to predict an L/S ≥ 2.2 showed that at all discriminatory points, the true positive rate is greater than the false positive rate and that the area under the ten curves is significantly greater than the area under the non diagnostic line ($p < 0.05$). A comparison of the area under the curve for twins versus singletons indicates that there is no significant difference between each curve ($p > 0.05$). Since all of the ROC curves were similar, Figure 1 is offered as a representative sample. It plots the true and false positive rates for a given FL, from 50 to 78 mm at 2 mm intervals, to identify a twin or singleton fetus with a mature L/S ratio. Table III lists the biometric measurements and estimates of fetal weights for the study and control populations, which are consistently (true positive rate of 100%) associated with pulmonary maturity. Using one of the sonographic criteria, significantly more fetuses of twin pregnancies were correctly identified as having a L/S ratio ≥ 2.2 (37/62) than singletons (13/46; $p = 0.0017$, RR 3.75, 95% CI 1.6 - 8.5).

Comments

The initial report on a noninvasive method to predict biochemical pulmonary maturity among twins and singletons is notable for three things. First, as noted by other investigators⁵, fetal lung maturity occurs at a much earlier gestational age with twins than singletons. It is

Table I. Maternal demographics

	Twins (n = 36)	Singletons (n = 72)	P value
Age (years)	24.5 ± 6.1	24.0 ± 5.7	0.67
Gravidity	2.6 ± 1.5	2.7 ± 1.5	0.74
Parity	1.4 ± 1.0	1.3 ± 1.1	0.40
Race			
African-Americans	31	62	
Caucasians	5	10	
Gestational age at amniocentesis (wks)	32.7 ± 3.0	33.2 ± 2.9	0.4
Indications for amniocentesis			
Preterm labor	18	36	
PPROM	14	28	
Others	2	4	

PPROM, preterm premature rupture of membranes

Table II. Gestational age (GA) and sonographic measurements of twins and singletons with pulmonary maturity

	Twins (n= 62)	Singletons (n = 46)	p value
GA at amniocentesis (wks)	33.2 ± 2.7	34.5 ± 2.5	0.01
BPD (mm)	80.2 ± 11.6	85.1 ± 7.5	0.01
HC (mm)	292.5 ± 27.3	296.7 ± 30.0	0.47
AC (mm)	276.8 ± 30.6	292.7 ± 39.1	0.02
FL (mm)	62.3 ± 6.2	65.4 ± 6.2	0.01
SEFW (gm)	1952 ± 561	2331 ± 771	0.003

BPD, Biparietal diameter; HC, head circumference; AC, abdominal circumference; FL, femur length, SEFW, sonographic estimate of birth weight based on BPD and AC.¹⁰

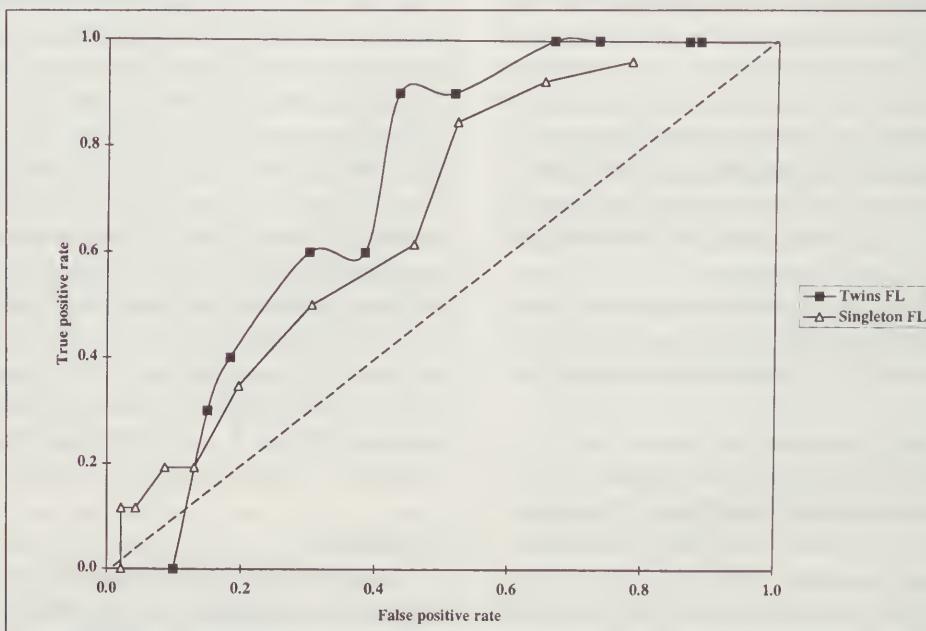


Fig 1.— Receiver-operating characteristic (ROC) curve for femur length (FL, from 50 to 78 mm at 2 mm intervals) to identify twin or singleton fetus with a mature lecithin/sphingomyelin ratio. The area (standard error) under the ROC curve for twins was 0.85 (0.05) and for singletons, 0.75 (0.04). In both cases the area under the curve is significantly greater than the area under the diagonal line ($p < 0.05$).

Table III. Based on receiver operating characteristic curves, the diagnostic threshold which is consistently associated with pulmonary maturity.

	Twins			Singletons				
	Diagnostic threshold	False positive rate	True positive rate	n	Diagnostic threshold	False positive rate	True positive rate	n
BPD (mm)	84	0.67	1.00	27	92	0.87	1.00	9
HC (mm)	315	0.52	1.00	14	320	0.91	1.00	8
AC (mm)	295	0.65	1.00	24	350	0.91	1.00	13
FL (mm)	64	0.62	1.00	29	72	0.89	1.00	7
SEFW (gm)	2400	0.76	1.00	11	3200	0.78	1.00	10

BPD, Biparietal diameter; HC, head circumference; AC, abdominal circumference; FL, femur length; SEFW, sonographic estimate of birth weight based on BPD and AC.¹⁰

apparent that there are yet to be determined factors, intrinsic to twin gestations, which are and lead to enhanced pulmonary maturation relative to the case of singletons. While it is beyond the scope of this paper to speculate on the mechanism (s) for these differences, the earlier onset of biochemical lung maturation in twins would appear to be a protective adaptation, given their high prevalence of preterm birth.

Second, among singleton pregnancies a BPD of 92 mm or more is consistently associated with L/S ratio ≥ 2.2 . Fourteen years earlier, in a totally different population, Golde et al⁸ similarly noted that if the BPD ≥ 9.2 cm the newborns did not have clinical evidence of respiratory distress syndrome. The fact that these two reports proposed an identical diagnostic threshold for BPD to predict pulmonary maturity lends credence to the use of sonographic examination to ensure fetal lung maturity. Moreover, if true for singletons, then the same noninvasive method should be applicable to twin gestations. Considering that not only the gestational age when pulmonary maturity occurs but also the growth pattern of biometric parameters is different among twins and singletons¹³, it is not surprising that the diagnostic threshold to avoid amniocentesis is different in the two clinical conditions.

The third finding of this study is that for both types of pregnancies, any one of the four biometric parameters or an estimate of birth weight can ensure biochemical pulmonary maturity (Table III). Since the two groups were matched for maternal demographics, gestational age, obstetrical complications, and had a similar incidence of mature L/S ratios, it is difficult to explain why a significantly higher percentage of twins with a L/S ratio ≥ 2.2 (59%) can be correctly identified with sonographic examination than singletons (28%). Admittedly, with the high false negative rate, fetal maturity may be present

even though none of the five sonographic parameters suggest it. Thus, in the absence of the five diagnostic thresholds (Table III), amniocentesis with biochemical test to assess fetal lung maturity is warranted.

A concern with the use of ultrasonographic examination of the fetus to infer pulmonary maturity is that there is interobserver and intraobserver variability in measurements of biometric parameters.¹⁴ Thus, before this concept is widely used, it should not only be validated in different population setting, but the diagnostic threshold to predict biochemical maturity may require modification. Another potential problem with this noninvasive method is the issue of false positive results. However, even the L/S ratio has a false positive rate and since amniocentesis is an invasive procedure, which may not be feasible in all clinical situations and has procedure related complications, the use of sonography may be very cogent.

In conclusion, if other investigators, using different types of biochemical tests to predict pulmonary maturity, confirm that sonographic examination of the fetus can accurately predict biochemical maturity, then this noninvasive technique may obviate the need for amniocentesis in certain women with twin and singleton pregnancies.

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Suneet P. Chauhan, MD, Associate Professor, Department of Obstetrics and Gynecology, Maternal Fetal Medicine, Medical College of Georgia, Augusta, Georgia.

Everett F. Magann, MD, Associate Professor, Department of Obstetrics and Gynecology, Maternal Fetal Medicine, University of Mississippi Medical Center, Jackson, Mississippi.

John C. Morrison, MD, Professor and Chairman, Department of Obstetrics and Gynecology, University of Mississippi Medical Center, Jackson, Mississippi.

A. Dawan Gunter, MD, Assistant Professor, Department of Obstetrics and Gynecology, Maternal Fetal Medicine, Medical College of Georgia, Augusta, Georgia.

Neil S. Whitworth, PhD, Professor and Director, Research, University of Mississippi Medical Center, Jackson, Mississippi.

Lawrence D. Devoe, Professor and Chair, Department of Obstetrics and Gynecology, Maternal Fetal Medicine, Medical College of Georgia, Augusta, Georgia.

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Corresponding author: Suneet P. Chauhan, MD
Spartanburg Regional Healthcare System
853 North Church Street, Ste 403
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There's Another Doctor in the House- Introducing Rep. Chester W. Masterson, M.D.

Karen A. Evers

Chester W. Masterson had never held a political office. For 31 years he practiced medicine as an otolaryngologist in Warren and surrounding counties. He has served the citizens of District 54 in the most personal of ways, by attending their health care needs. Now he serves them as their State Representative in the Mississippi Legislature.

Responding to a question about what inspired him to run as an elected official and his qualifications for office, Representative Doctor Masterson wasn't quite sure. "Except that I am very interested in the State of Mississippi and its citizens having the best state government possible for their betterment."

"I have represented the ophthalmologists and the opticians for 30 years and the Mississippi State Medical Association (MSMA) for several years by going to committee meetings and testifying before these committees. I decided that I liked the Legislature. After retiring, January 1, 1997, and deciding that it wasn't for me, when the seat became available I decided to run."

A glimpse at Masterson's MSMA membership file proves that Masterson is qualified as a respected leader in his profession and his community, as a family man with family values, and as a concerned advocate who understands both the business and health care needs of our state.

His concern for Mississippian's health care needs is that of many physicians... available and affordable health care. "This to me is a tough item. I have seen many people that could not get medical care when needed due to lack of money, lack of transportation, or the necessities to travel to the area where the care was available. While every physician gives a lot of free care and the hospitals set aside a certain amount of money for indigent care every year, it

is not common knowledge that it is available," he said.

Presently, he is on the Board of Directors and a stakeholder in a 3 million dollar Robert Wood Johnson grant for Medical Access to Rural Care (MARC). "We plan to do several things to improve medical care in the rural areas of our state. We plan to do this through pipelining, networking, recruitment and retention of medical care givers, and establishing a loan program."

Masterson explained, "We plan to establish a pipeline throughout the state to get the word out that there is a great need for rural health care givers. We plan to go to the schools, colleges, local service and civic clubs, churches, and anywhere boys and girls gather, to get the message out. We are attempting to begin networking between several local hospitals, between small hospitals and larger urban hospitals, and the University of Mississippi teaching hospital. Physicians and other health care givers are included. With modern technology this can be accomplished and by networking better medical care can be provided more cost-efficiently. By networking hospitals will be able to purchase at reduced cost," he said.

"It is surprising how much money is in this state earmarked for rural health care. Many governmental agencies, private coalitions and grant holders have money for rural health care but there is no central entity to coordinate the services. The need of utmost importance is making it a priority to develop that entity, whether it is a government agency or a private concern to coordinate all the entities involved in rural medical care. We need to be working together so that the efforts are not duplicated and triplicated as is now the case, therefore improving efficiency and decreasing the costs."

Like a politician giving his stump speech, Masterson



Mississippi Rep. Chester W. Masterson, M.D., District 54, brings another physician's perspective to the Legislature.

continued, "We are going to help local communities with recruitment and retention of physicians and allied medical care personnel to their communities. We have the management system and the personnel in place. Now we need the cooperation of the rural hospitals, physicians, communities, and other health care givers."

Another component of MARC is a plan to set up a loan program which will pay the tuition to medical school

"My special interests are promotion of improvements in education, available and affordable medical care, and fiscal responsibilities within the Legislature of the taxpayers money."

Chester W. Masterson, M.D.

Born: Quitman County, MS.

Graduated: Crowder High School, attended Northwest Mississippi Junior College and The University of Mississippi.

Medical Education: M.D. from the University of Tennessee in Memphis, 1960. Interned Baptist Memorial Hospital in Memphis. General Surgery Residency at Kennedy Veterans Hospital (Memphis) and ENT-EENT Hospital at Tulane University (New Orleans).

Military: Drafted into the U.S. Army and served two years of service in Japan in the Medical Corps. as a corpsman during the Korean Conflict.

Family: His wife of 42 years, Martha Ann Gordon Masterson of Batesville, four grown children and ten grandchildren.

Community Honors: Member of the Vicksburg Jaycees. Has been a member of the Rotary Club ever since he moved to Vicksburg in 1966, a past president of that club.

Organized Medicine Leadership: Served as the 1998-1999 Chairman of the Board of Trustees of the Mississippi State Medical Association, having served on that Board for six years. Past President of West Mississippi Medical Society; the Eye, Ear, Nose and Throat section of the MSMA and the Mississippi Eye, Ear, Nose and Throat Association. Former trustee of the Columbia Vicksburg Medical Center and member of the medical staff executive committee of Parkview Regional Medical Center. Former member of the American Academy of Otolaryngology, the Louisiana-Mississippi O & O Society and the Mississippi Chapter of the American College of Surgeons.

Church: First Baptist of Vicksburg, where he has served as Chairman of the Deacons and Chairman of the Finance Committee.

or an allied health school. Students' educations will be reimbursed by practicing in a medical care shortage area for a certain number of years. This is similar to the scholarships for teachers and the National Health Corps.

Masterson feels the most critical legislative issue facing physicians this year is trying to prevent the encroachment upon the practice of medicine by non-physician persons. "The scope of medical practice is being invaded from all sides. Various bills are being introduced by gregarious groups to increase the scope of practice on behalf of optometrists, chiropractors, podiatrists and nurses and a few others. Physicians, with medical doctorate degrees, licensed by the Mississippi State Board of Medical Licensure, are going to have to protect their authority and expertise as providers in the realm of the physician-patient relationship," he said.

Another important legislative issue this year will be expenditure of the tobacco trust fund. "Everybody's mouth waters when they see the money in the tobacco trust fund. However, with our present chairman of the Public Health and Welfare Committee, I think it is safe for the present," Masterson said.

Education is also of special interest to Masterson. "I certainly agree that the first step is to attempt to get our teacher pay up to the Southeastern average pay. Then we should go to a combination of merit pay raises and teaching evaluations to upgrade or downgrade teacher pay. I do not think we have the tools in place at this time to accurately evaluate teachers for upgrade or downgrade pay. During this time frame, we should certainly be in the process of developing tools for evaluation that are fair to the students, parents, teachers, and administrators who must do the evaluation, and the taxpayers.

Masterson believes in community schools rather than megaschools. He believes that better relationships between students and faculty, as well as parents and faculty, are much easier to establish in community schools than in megaschools. "There is usually a better ratio of students to faculty so that the students get more personal attention making for a better teaching and learning environ-



Rep. Chester W. Masterson, M.D. comments on a floor debate.

What is the one thing you would like to see physicians do to be stronger advocates for patients rights? "Become more vocal before the public and the Legislature, especially your own legislators."



Now legislators carry lap-top computers that allow them to stay current on bills. Prior to getting the computers, lawmakers would be faced with stacks of bills on their desks.

ment, and one with less likelihood for violence," he said.

"My wife and I, and all four of my children graduated from public schools. All ten of my grandchildren that are old enough to go to school are in public schools and the younger ones will be in two to three years. Therefore, you can see that I have a real interest in seeing the public schools be the best they can," he qualified.

Masterson feels strongly about fiscal responsibilities. "I believe in careful spending. I believe the budget should be balanced as required by state law. I believe that adequate spending should be done to improve the state and therefore the people of Mississippi, realizing that the government cannot be anything and everything for the individual," he said.

"One of my big concerns is that nearly every year

recently, the revenue intake has been allotted before the end of the legislative session and then bonds are issued for capital improvements, schools and other reasons. My question to many of the ranking members of the Legislature is 'Why?' I am told and almost always receive the same response that Mississippi has such a good bond rating that bonds can be issued at about 6% and that the state has only 1/10 to 1/6 of the total capacity of the state's ability to issue bonds. That is all well and good, but when those bonds mature the money will have to be repaid. Who will do this? You and I as taxpayers, our children and grandchildren," he questioned.

"During the last legislative session, 350 million dollars worth of bonds were issued that the state will have repay. This brings it up to 35% of the state's capacity to issue bonds. A few years ago the state's indebtedness annual payment was 13 million dollars, but that payment this year was 268 million dollars," he explained.

"To me it is ill advised to increase the state's indebtedness while our economy is as good as it now and when it is very possible. It will not be as good when it comes time to pay off the bonds. I think that the Legislature should take its fiscal responsibilities seriously and spend within its incoming revenue and not increase the debt," he said.

"I believe with serious fiscal responsibilities by the legislators that the taxpayers could be returned a portion of their money in the form of a tax cut, whether it be in the form of an across the board decrease in taxes or rescinding the sales tax on food and medicines," he added.

How do you think you can make an impact on medical legislation? "I know the legislators and they know me by being at the capital so much, going to committee meetings and serving as Doctor of the Day for many years. I was appointed to the Public Health and Welfare Committee, my first choice. I believe my voice will be heard and considered on this committee.

Masterson serves on the County Affairs, Insurance, Judiciary B and Public Welfare committees, three of his top committee requests.

In closing I asked him if there were anything he would like to add. "I would like to thank every member of MSMA who encouraged me by their words and backed me during my political campaign."



Masterson joins Rep. Jim C. Barnett, M.D., who was the only physician in the House before Masterson was elected. Dr. Barnett has represented Brookhaven's District 92 for the last nine years. With a specialty in family practice and general surgery, he had served Brookhaven as a physician for 36 years.



Ask And You Shall Be Informed

W. Briggs Hopson, Jr., M.D. The President's Page

Your American Medical Association is going around the country challenging people in all walks of life to ask critical questions to all those who are running for election this year. This campaign is called the AMA's NATIONAL HOUSE CALL. The name capitalizes on a phrase uniquely identified with physicians and it emphasizes the campaign goal of going directly into local communities to listen to citizens' concerns. It is a campaign to bring into focus the health care issues that are paramount in this country.

The AMA mobile campaign headquarters (pictured adjacent) is currently taking AMA and medical society leadership and issues on the road, traveling to key primary states and to the highest-magnitude advocacy and public health venues between now and election day 2000, delivering medicine's message, rallying physicians, mobilizing patients, and making certain that both the presidential and congressional candidates debate medicine's issues and address medicine's concerns.

In various areas the AMA and medical society leadership meet with editorial boards, conduct news conferences, build stronger bonds with rank-and-file membership, hold public venues and encourage citizens to ask those running for office a number of critical health care questions. It is important that we as physicians encourage our citizens to know what those running for office stand for.

As a part of this effort, I hope that you will take this article and ask your patients to ask those running for election these questions:

- 1) Does the candidate support a meaningful patient bill of rights?
- 2) Does the candidate believe physicians, not insurance plans, should determine what is medically necessary for you and your family?
- 3) Does the candidate believe that HMOs should be accountable for treatment decisions that harm patients?
- 4) Does the candidate support health insurance coverage for all Americans?
- 5) Does the candidate support tax-based incentives to make it easier for American families to afford health insurance?
- 6) Does the candidate have a plan to reform Medicare?

Only by asking these questions and getting the answers, and only through education, can we make our patients aware of what Congress has in store for them. The average patient does not realize what the patients' bill of rights stands for. The average citizen does not realize the difficulties that physicians face with the inability to do collective bargaining. The average citizen does not realize how many people are uninsured in this country, Mississippi having over 20% of its population uninsured. The list goes on and on, and we as physicians in the state of Mississippi must join with the AMA to educate our populace and ask them to ask the right questions. We as physicians must become true patient advocates, and we must ask ourselves, as we ask our political leaders, "Is it good medicine?"

A handwritten signature in black ink, appearing to read "Briggs".



We're delivering the biggest issue any candidate will face this year.

You're looking at one of the AMA's special mobile campaign headquarters. As part of our National House Call campaign, they'll call on key primary states, delivering a strong message to every presidential candidate. A message we hear from patients every day.

The message is simple. Patients want every candidate – Republican, Democrat and Reform – to make a firm commitment to address those critical health care issues in this country that remain unsolved. The kinds of problems that affect the security and well-being of families nationwide.

Shouldn't all Americans have health care coverage? Shouldn't patients have the right to hold their health plan accountable when things go wrong? Shouldn't doctors have the final say on what's medically necessary? And shouldn't Medicare be secure for our grandchildren?

We believe you should hear from the candidates on these questions before you vote. Just as we believe the best way to ultimately answer all questions about health care is by asking one more question. The one question that can bring proper focus to the debate, establish common ground and be an invaluable guide in designing effective new solutions.

Whenever health care is at issue, this is the only real question: **Is it good medicine?**

American Medical Association

Physicians dedicated to the health of America



Find out what physicians of the AMA have to say on issues important to you and your doctor at www.ama-assn.org/grassroots

DAM THOSE LAWYERS

It started as a tiny trickle. Imperceptibly it became a steady stream. And I'm talking rural central Mississippi.

The scenario is almost always the same: The frightened patient, envelope in hand, rushes into the office insisting that his physician explain the ominous report he has just received.

Apparently the patient had responded to an ad himself or had been solicited by a law firm seeking workers with possible exposure to asbestos. And before you could say "Wilhelm Conrad Roentgen", arrangements had been made for chest x-rays. I can even envision van loads of clients/patients collected from the back roads of Attala County transported en masse to Jackson with the promise of an all-you-can-eat food voucher.

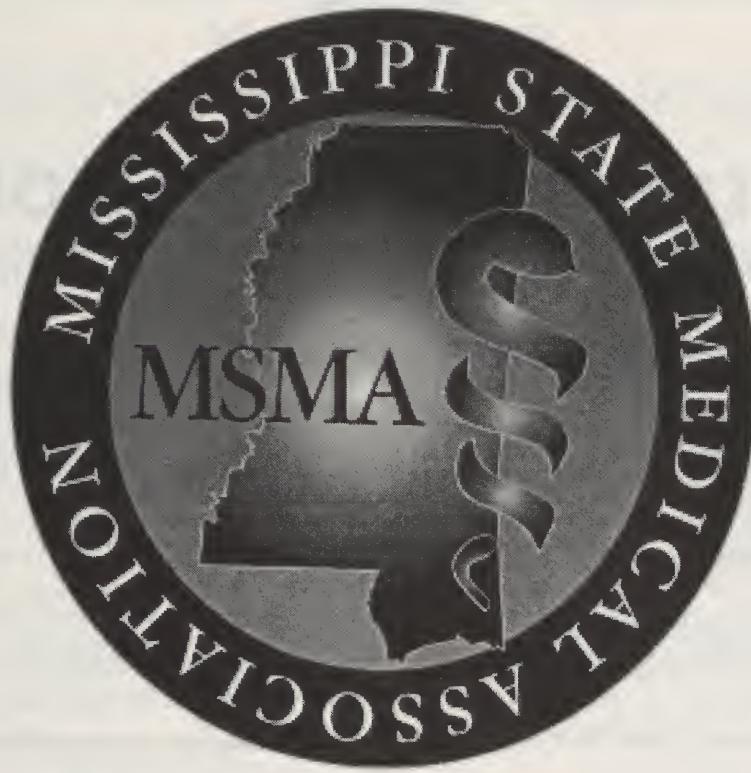
Strangely enough, all of the x-rays have been interpreted by the same radiologist, and the reports I've seen have looked like carbon copies of one another: "...Irregular interstitial opacities are observed throughout both lungs ... Bilateral interstitial fibrotic changes consistent with asbestosis in a patient who has had an adequate exposure history and latent period."

Up to now I've been successful in pleading ignorance and deferring to the attorney and/or radiologist for patient enlightenment. However, if I'm ever backed into a corner, I can imagine that my answer might sound something like this: "It's one of those good news/bad news deals. I suspect that you (and the attorney and the radiologist) will one day be awarded a sum of money. If the x-ray report is correct, I just hope and pray that your portion doesn't have to be spent for treatment of a mesothelioma."

Just when the floodgates seemed to be inching closed, a new wave has hit without warning: Former Fen-phen users clutching their echocardiogram reports. Politics notwithstanding, medicine makes its own share of strange bedfellows.

—Stanley Hartness, M.D.
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



**132ND
ANNUAL SESSION
&
SCIENTIFIC ASSEMBLY
PRELIMINARY PROGRAM**

**May 18 - 21, 2000
Beau Rivage Resort
Biloxi, MS**



GENERAL INFORMATION

REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in references committee meetings as policies of the Association are established. All meetings will be held consecutively.

The schedule is as follows:

2:00 PM	Reference Committee on Constitution and Bylaws
2:30 PM	Reference Committee A
4:00 PM	Reference Committee B

CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours for this session will be listed in the official program of the 132nd Annual Session.

MACM GOLF TOURNAMENT

Medical Assurance Company of Mississippi will reinstate the tradition of sponsoring its annual golf tournament. The tournament will be held at Great Southern Golf Club, 1:00 PM., Thursday, May 18. Prizes will be awarded.

Members and their spouses are invited to all social events which are all complimentary except the **President's Inaugural Celebration** (Black Tie Optional), to which tickets may be purchased at a nominal charge to offset costs.

THE PRESIDENT'S RECEPTION

The annual **President's Reception** will be held Friday evening, May 19, on the Beau Rivage Special Events Deck overlooking the Gulf, from 6:30 P.M. to 8:30 P.M. Enjoy the "Rhythm of The Islands" with steel drum music performed by David Wahl. Since their inception in 1987, *The Tropical Steel Band* has been one of the most truly innovative and entertaining musical groups along the Gulf Coast. Following the reception, guests are invited to an ice cream social sponsored by Southern Medical Association.

MSMA PRESIDENT'S INAUGURAL CELEBRATION AND MSMA ALLIANCE SILENT AUCTION

With the beginning of new Millennium, MSMA will initiate a new practice of conducting the President-elect's Inauguration on Saturday evening, rather than during the closing session of the House of Delegates on Sunday morning. This very special dinner/dance event, which will be black tie optional, will include the inauguration of Dr. Candace Keller as MSMA's 133rd President, special recognition of MSMA's component society Presidents, the MSMA Alliance's annual Silent Auction to benefit the AMA Foundation, and entertainment by several celebrity guests performers. All MSMA and MSMA Alliance members will receive an invitation and information about purchasing tickets for this memorable and fun evening.

COMPONENT SOCIETY CAUCUSES

If your component society plans to hold a caucus you need to contact Karen Evers to reserve a location a.s.a.p. Planning for meeting rooms has already occurred and there is limited space for small groups.

MSMA 132nd Annual Session and Scientific Assembly

May 18-21, 2000

Beau Rivage • Biloxi, MS • 1-888-567-6667

PRELIMINARY SCHEDULE

THURSDAY, MAY 18

1:00 p.m.	Registration
	MACM Golf Tournament
2:00 p.m.	Exhibitor set-up
4:00 p.m.	Board of Trustees Meeting

FRIDAY, MAY 19

7:30 a.m.	Continental Breakfast with Exhibitors (Sponsored by Horne CPA Group)
	MS Eye, Ear, Nose & Throat Association Breakfast
8:00 a.m.	Registration
	Reference Committee Orientation
9:00 a.m.	House of Delegates
11:00 a.m.	Lunch with Exhibitors
	Alliance Pre-Convention Lunch Meeting
11:30 p.m.	Mississippi Association of Public Health Physicians Meeting
	Board of Trustees Meeting
12 noon	MMPAC Board of Directors Meeting
	Young Physician's Section (YPS) Business Meeting
	Information & Quality Healthcare (I.Q.H.) Annual Meeting
2:00 p.m.	Reference Committee on Constitution and Bylaws
2:30 p.m.	Reference Committee A
4:00 p.m.	Reference Committee B
6:30 p.m.	President's Reception
9:00 p.m.	Southern Medical Association Coffee and Dessert Party

SATURDAY, MAY 20

7:00 a.m.	Women in Medicine Breakfast
	Specialty Society Breakfast: Mississippi Section of the American College of Obstetricians and Gynecologists

7:30 a.m.	Registration
	Continental Breakfast with Exhibitors
7:30 a.m.	Board of Trustees Meeting
	Specialty Society Breakfasts: MS Chapter of the American College of Surgeons
	MS Society of Anesthesiologists
	Past President's Breakfast
	Fifty-Year Club Breakfast
8:30 a.m.	Plenary Session
	Alliance Welcome and Coffee
9:00 a.m.	Alliance House of Delegates Meeting
	MS State Dermatology Society Meeting
11:00 a.m.	Alliance Luncheon / Installation of Officers
11:30 a.m.	MPCN Board of Directors Meeting
	Committee on Publications Lunch Meeting
	Specialty Society Luncheons: MS Chapter of ACEP
	MS Academy of Family Physicians
	MS Chapter of the American College of Surgeons
	MS State Dermatology Society
1:00 p.m.	Plenary Session
4:00 p.m.	Component Society Caucuses
	Central Medical
5:30 p.m.	University of MS Alumni Reception
6:30 p.m.	MSMA President's Inaugural Celebration
	MSMA/MSMA Alliance Reception and Silent Auction

SUNDAY, MAY 21

7:00 a.m.	Board of Trustees Meeting
7:30 a.m.	Registration
	Continental Breakfast for Members
8:00 a.m.	Worship Services
8:30 a.m.	Alliance Past-Presidents' Breakfast
9:00 a.m.	House of Delegates
11:30 a.m.	Board of Trustees Meeting
12 noon	Board of Trustees Luncheon

“MEDICAL AFFAIRS FORUM 2000”

(PRELIMINARY PLENARY SESSION SCHEDULE)

SATURDAY, MAY 20 • MAGNOLIA BALLROOM

8:30 A.M. **“RISK MANAGEMENT”**

- **Whitman B. Johnson, III, Esq.**

Currie, Johnson, Griffin, Gaines & Myers

Sponsored by the Medical Assurance Company of Mississippi
(MACM)

9:45 A.M. **“MEDICAL STAFF BY-LAWS: THE GOOD, THE BAD AND THE UGLY”**

- General Counsel, American Medical Association

11:30 A.M. **LUNCH BREAK**

1:00 A.M. **“HEALTH CARE LEGISLATION AND THE 107TH CONGRESS”**

- **Mr. Julius Hobson**, Director of Congressional Affairs
American Medical Association

2:00 P.M. **“CHEMICAL IMPAIRMENT AND THE MISSISSIPPI RECOVERING PHYSICIANS PROGRAM”
(MRPP)**

- **Gary Carr, M.D.**, Medical Director of the Mississippi Recovering
Physicians Program

3:00 P.M. **“OPHTHALMOLOGY UPDATE: LACIK (LASER EYE SURGERY) AND
INTACS (CORNEA RING IMPLANT SURGERY)”**

- **Connie McCaa, M.D.**, Director of Corneal Services
Professor, School of Medicine
University of Mississippi (UMC) Medical Center

- **Robert Mallette, M.D.**

Clinical Assistant Professor of Ophthalmology
University of Mississippi (UMC) Medical Center

4:00 P.M. **ADJOURN**

**PLENARY PROGRAMS PLANNED BY MSMA's:
COUNCIL ON SCIENTIFIC ASSEMBLY**

TECHNICAL EXHIBITS

MSMA 132nd Annual Session

EXHIBITORS (as of JOURNAL MSMA Press Date)

Abbott Laboratories
Chandler-Sampson Insurance, Inc.
Coastal Insurance Enterprises, Inc.
Doctors Insurance Reciprocal
Executive Planning Group
Health Link
Information & Quality Healthcare (I.Q.H.)
Medical Assurance Company of Mississippi
Merck Human Health Division
Mississippi Physicians Care Network
MS State Department of Health
MSMA Benefit Plan & Trust
Pfizer, Inc.
UAB Health System
United HealthCare



Mississippi State Medical Association Alliance

77th Annual Session
May 18-21, 2000
Beau Rivage Resort
Biloxi, MS

THURSDAY, MAY 18

1:00 PM - 4:00 PM Registration

FRIDAY, MAY 19

8:00 AM - NOON Registration
11:00 AM Pre-convention Board Meeting/Luncheon
6:30 PM MSMA President's Reception

SATURDAY, MAY 20

8:30 AM Alliance Welcome and Coffee
9:00 AM House of Delegates
11:30 AM Luncheon/ Installation of Officers
2:00 PM Post-convention Board Meeting
6:30 PM MSMA/ MSMAA Membership Reception
& AMA Foundation Auction
MSMA President's Inaugural Dinner Dance

SUNDAY, MAY 21

7:00 AM MSMAA Past Presidents' Breakfast

Seeking Nominations for the 2000 MSMA Community Service Award

The **Annual Physician Award for Community Service**, sponsored by Mississippi State Medical Association is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. All nominations should be submitted to the Mississippi State Medical Association by March 1, 2000.

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. **A \$500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the person's community involvement.

Nominations should be sent to MSMA, P.O. Box 2548, Ridgeland, MS 39158-2548, as soon as possible but no later than March 1, 2000. For further information please contact: Karen Evers, Director of Communications, (601) 853-6733 or 1-800-898-0251.

Address to the AMA Alliance Confluence

Nancy Lindstrom, AMPAC Board of Directors

Much has been made about the millennium — about the beginning of a new century. We survived the transition from 99 to double zero with ease. And now we have another milestone facing us. The first elections of the first century of this millennium.

These elections, of course, are significant because they are the first to be held in the 21st century. Perhaps more importantly, though, is the balance of power that likely will be decided in about nine months.

I bring this up because we, as members of the medical community, have a tremendous stake in the outcome of these elections. And we, as members of the medical community, have the power to impact that outcome.

Several recent nationwide polls confirm that health care issues have moved to the top of the national policy agenda. An October 1999 Washington Post poll found that health care issues were cited as three of the top five concerns of voters. The number one concern of voters was that insurance companies are making decisions about medical care that physicians and their patients should make. This concern about HMOs was ranked first by Democrats, Republicans and Independents.

Two other findings you may be interested in - that 59 percent worried that elderly Americans won't be able to afford prescription drugs. And that 55 percent worried medical benefits that they and their families receive will be reduced or eliminated.

So we know that health care is a major concern for the general public. But what about the candidates, the politicians? The presidential candidates and key interest groups are committed to making coverage for the uninsured a priority issue for the 2000 elections. We've seen the Democratic presidential candidates announce health

care proposals, and have listened to the Republicans as well on this subject.

The public cares deeply about this issue. Our presidential contenders are concerned about it. House and Senate candidates are concerned about it as well.

I have one other variable to throw into this equation to prove how much impact we can have in November.

Currently there are 27 open seats in the US House and six open seats in the US Senate. In the House, Republicans have a slim 11-seat majority, and in the Senate they lead by ten.

The outcome of this equation — of the November elections — is uncertain.

The answer remains to be determined. I can tell you what hangs in the balance — that control of the House and Senate may change, and that no one knows who is likely to occupy the White House next January.

But out of this uncertainty comes our opportunity. I can think of no other time since I've been involved in politics when the variables came together to create a favorable environment for us, as members of organized medicine, to impact campaigns to such a high degree.

We have physicians running for reelection from the US House and Senate; we have more seeking election to federal, state and local offices around the country. Our issues are at the top of the campaign and legislative agendas. And our issues are a high priority with voters as well.

We must not let this historic chance pass by. We must continue our leadership among our peers and within our community to positively impact this legislative and political agenda on behalf of medicine — on behalf of our spouses' profession and on behalf of patients.

So, what do I suggest?

- Join AMPAC. Your membership, combined with thousands of others, speaks loudly to candidates. It's only \$50 for Alliance members — a bargain for what it accomplishes.

- Enroll in the AMA Physicians' Grassroots Network. You'll receive legislative updates and action alerts. This is especially important this year when the outcome of the Patient's Bill of Rights and antitrust legislation hangs in the balance.

- Take part in a campaign. You can play a critical role in campaigns, in an effort to ensure that friends of medicine are victorious. Your activities can range from acting as a volunteer in the office, attending a fundraising event, preparing issue materials or even acting as a campaign manager. Which brings me to the next level.

- Attend the AMPAC Campaign School the next

time it is offered. The School is a tremendous resource for those who are able to take advantage of it.

Our involvement in political and legislative grassroots activities is the cornerstone of the AMA and AMPAC efforts. Alliance members serve on PAC boards around the country. We assist our local candidates in their election efforts. We meet with our elected officials and present medicine's legislative concerns.

If we continue and expand these activities on behalf of organized medicine, the outcome of the November elections this political equation — will benefit America's patients and it will benefit America's physicians.

Nancy Lindstrom lives in Laurel, is an active member of the South Mississippi (Jones County) Alliance and is married to Dr. Eric Lindstrom, an ophthalmologist.

UNKEMPT APPEARANCE BEHAVIORAL CHANGES BLOOD-SHOT/BLEARY EYES NOT THE SAME GUY HE USED TO BE UNAVAILABLE ON CALL UNUSUAL HIGH DOSE OR USAGE NOTED IN DRUG USE

Sometimes doctors need help too

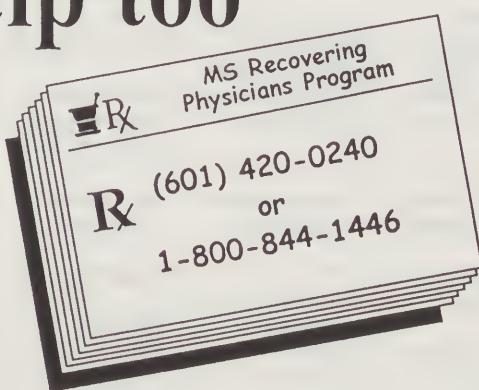
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FAMILY PROBLEMS DWI ARREST OR VIOLATIONS EXCESSIVE PRESCRIPTION WRITING ALCOHOL ON BREATH WHILE ON DUTY

The Mississippi State Medical Association
 Alliance Board and County Chairs
 Want to Wish All of the
 Doctors of Mississippi

“Happy Doctors’ Day”

CENTRAL Angela Buyers Robin Tucker	County President County President	Debra Carr Martha Clippinger	MS Recovery SMA Councilor- Medical Heritage, Beavoir	Charmain Thompson	MSMA Director of Government Affairs
COAST Patricia Benefield Carol Reeves Pam Storey	County President AMA Chair County President	Peggy Crawford Lori Edney Cathy Gersh	Advisor, Medical Service, PR, SMA, Head, Nominating Foundation Committee Past President, Nominating, Reading	Jo Waites Silvia Walker Barbara Webb Mary Jane Wooten	Council on Public Info, Beavoir Nominating By-Laws Third Vice- President, WMMA AMA Chair
COLUMBIA Tammy Johnson Martha Whitehead	County President AMA Chair	Sharon Guild Jean Hill	Treasurer Special AMA Advisor, MMPAC/AMPAC		
EAST Iris Boggan	AMA Chair	Nora Hillier Ann Hopper	Foundation Committee President-Elect, Reading, Publications	NORTH CENTRAL Nell Middleton	AMA Chair
HOMOCHITTO VALLEY Delicia Carey President Sue Purvis	County AMA Chair	Danita Horn Melisa Irby Angela Ladner Jane Ladner	Second Vice-President SMA Councilor - Doctors' Day Recording Secretary Parliamentarian, Nominating	NORTHEAST Sandra Hudson Dot McDuffie	AMA Chair County President
LEE COUNTY Kim Buckley Susan Rish Rusty Roden Theresa White	AMA Chair County President County President AMA Chair	Nancy Lindstrom Eilene McRae Melanie Moore Jeanne Morrison	Advisor, Council on Legislation MS Recovery Foundation Committee Advisor, Finance Committee	OKTIBBEHA Kathy Edmondson	County President
LOWNDES Karolyn McCain Sandra Woodard	County President AMA Chair	Susan Pickard Emily Pickell	Fourth Vice-President Resident Spouse Alliance President	SINGING RIVER Linda Barnes Monica Donald	AMA Chair County President
MSMAA Linda Beasley Elinor Benefield Nancy Bush Misty Campbell Kathy Carmichael	Foundation Committee Beavoir Advisor, Nominating Student Spouse Alliance President Advisor, Nominating	Jane Preston Kim Reed Carol Reeves Merrell Rogers Mary Helen Schaeffer Barbara Shelton Peggy Sprayberry Martha Tatum	Archives and History, Beavoir First Vice-President Foundation Committee MMPAC/AMPAC President, Publications Staff Executive Health Promotions Memorial, Beavoir	So-MS-HATTIESBURG Gail Atkinson Jan Howard	AMA Chair County President
				So-MS-LAUREL Catherine Nowicki Celeste Vial	County President AMA Chair
				WASHINGTON Susan Cirilli Laura Gilespie	County President AMA Chair
				WEST Ms Lisa Boleware	County President

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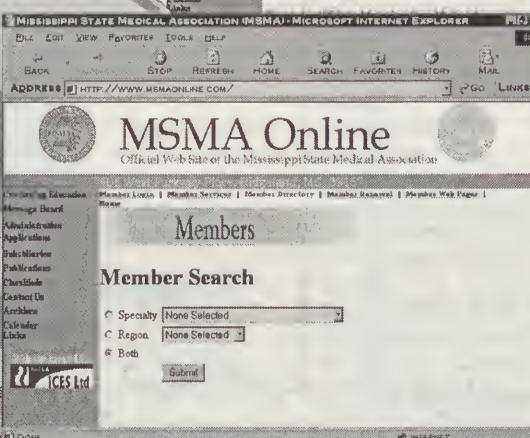
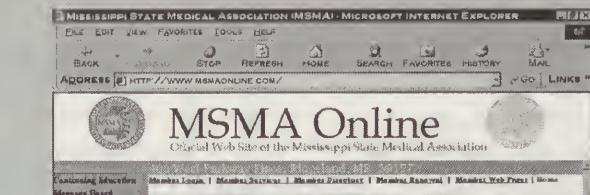
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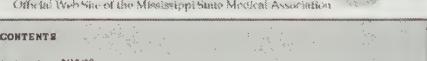
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Cover photo: R. C., "Corky" Sneed, M.D., Pediatrician, Physical Medicine and Rehabilitation Specialist, Medical Director of Children's Rehabilitation Center, University Medical Center, took this Spring photo at Mynelle Gardens. Created through the dedication of Mynelle Westbrook Hayward, a Jackson native with a national reputation in flower arranging and gardening, Mynelle Gardens displays azaleas, daylilies, camellias, annuals, naturalized bulbs and hundreds of perennials in carefully landscaped settings. Mrs. Hayward travelled widely, gathering rare flowers and gaining inspiration for the gardens she maintained around her home on Clinton Boulevard. Despite the close proximity to downtown Jackson, the mood is always tranquil. Recently placed on the Historic Register, the gardens were purchased by the City of Jackson in 1973 and are now maintained by the city with the help of many devoted community volunteers.

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I.Q.H., Information and Quality Healthcare: Improving the Care of Patients with Acute Myocardial Infarction and Congestive Heart Failure

Candace E. Keller, M.D., MPH

Two of the national topics in the Health Care Financing Administration's (HCFA) quality improvement initiative focus on improving the care of patients with acute myocardial infarction and congestive heart failure. This initiative is being carried out through quality improvement organizations around the country, including I.Q.H., Information and Quality Healthcare in Mississippi. This article will present the quality indicators being examined as well as their statewide baseline measurements which have identified significant opportunities for improvement. Already 29 Mississippi hospitals have agreed to work cooperatively with I.Q.H. on a number of these key indicators.

Heart failure is the leading cause of hospitalization for Mississippi Medicare beneficiaries. In 1998, statistics showed 12,976 Medicare admissions for heart failure with an average length of stay of 5.7 days. Charges for these admissions in Mississippi alone totaled more than \$108 million. Similarly, acute myocardial infarction (AMI) is also one of the leading causes of admission, accounting for some 4,896 Medicare admissions with charges totaling more than \$90 million dollars in 1998 and an average length of stay of 7.2 days.

The baseline data figures shown below were obtained from abstraction performed by the Central Data Abstraction Center (CDAC) on a statewide random sample

Fig 1.— ACUTE MYOCARDIAL INFARCTION

Indicator	Baseline Data		
	Mississippi	Lowest State	Highest State
Early Administration of Beta Blockers	43.8%	43.8%	79.0%
Early Administration of Aspirin	79.5%	75.0%	90.4%
Time to Reperfusion (Median Time)	44.5 Minutes	31.0 Minutes	57.5 Minutes
Beta Blocker at Discharge	46.7%	46.7%	88.7%
Aspirin at Discharge	77.7%	76.8%	93.8%
ACE Inhibitor for Low LVEF	61.3%	56.8%	90.0%
Smoking Cessation Counseling	34.3%	24.3%	69.6%

of inpatient AMI Medicare charts of admissions between April 1 - September 30, 1998, in Mississippi and 18 other states. Patients with contraindications were omitted from the analysis. Thus, all remaining patients were considered to be "ideal" candidates for the therapy measured.

In comparison to the other 18 states, Mississippi's performance ranked in the lower one third on each of the seven indicators. On both of the beta blocker indicators, Mississippi had the lowest percent administration in this entire group of states. While some progress as a result of the Fifth Scope Cooperative Cardiovascular Project (CCP) has been made, many opportunities for improvement remain.

These indicators were chosen based on scientific evidence; extensive review and comment by a panel of cardiology experts, and consideration of technical data issues. They are consistent with the recommendations in the published clinical guidelines of the American College of Cardiology and the American Heart Association.

Multiple clinical trials have demonstrated the efficacy of aspirin, beta blockers, early reperfusion, and ACE inhibitors for appropriate patients with AMI, e.g., the Second International Study of Infarct Survival (ISIS-2). The early use of aspirin for patients with an evolving myocardial infarction was associated with a 23% reduction in short-term mortality. The reduction in mortality increased to 42% when aspirin was combined with streptokinase (ACC/AHA Guidelines, p.26). The 1999 ACC/AHA AMI Guidelines (*Class I*) recommend a dose of 160 to 325 mg should be given on day one of AMI and continued indefinitely on a daily basis thereafter for patients with no allergy to aspirin. Additionally, chewable aspirin absorbs more quickly.

The early use of beta blockers reduced short-term mortality from 4.3% to 3.7% in the First International Study of Infarct Survival. In the Metoprolol in Acute

Myocardial Infarction (MIAMI) trial, 15-day mortality was reduced from 4.9% to 4.3%. The 1999 ACC/AHA AMI Guidelines state: "Beta-adrenoceptor blocking agents may be given to patients with AMI to reduce morbidity and/or mortality during (1) the initial hours of evolving infarction and (2) the weeks, months, and years after completed infarction (secondary prevention)" (ACC/AHA Guidelines, pg.108).

The use of thrombolytic agents has been documented to be efficacious in the treatment of AMI. There has been great reduction in mortality for patients that receive thrombolysis promptly. The FTT (Fibrinolytic Therapy Trialists') group demonstrated a highly significant mortality reduction of 26% when therapy was administered within three hours of symptom onset. Therefore, the time from symptom onset to presentation for treatment to reperfusion is crucially important.

A number of clinical trials have shown a reduction in mortality in patients treated with ACE inhibitors whose ejection fraction is <40%. The AMI Guidelines state: "Data from these trials indicate that ACE inhibitors should generally be started within the first 24 hours, ideally, after thrombolytic therapy has been completed and blood pressure has stabilized" (ACC/AHA AMI Guidelines, p. 110-111).

These baseline figures shown below (Figure 2.) were likewise obtained from a random statewide sample of Medicare CHF admissions between April 1, 1998, and September 30, 1998, abstracted by the CDAC. Analysis of the data was performed so that credit was given for appropriate use of Angiotensin converting enzyme inhibitors (ACEI) in patients with an ejection fraction (EF) of < 40% as well as non-use in patients if the EF was >40%. Mississippi's performance on these discharge measures compares favorably with that of the other 18 states in the group, but some marginal room for improvement still

Fig 2.— CONGESTIVE HEART FAILURE

Indicator	Baseline Data		
	Mississippi	Lowest State	Highest State
Appropriate use/non-use ACE Inhibitor at Discharge	74.0%	71.1%	87.4%
Appropriate use/non-use ACE Inhibitor OR ARB at Discharge	75.3%	73.1%	88.3%
Documentation of Ejection Fraction Before or during Admission	58.3%	34.5%	79.0%

remains. Significant opportunity remains to improve the documentation of evaluation of the ejection fraction before or during the admission of heart failure patients not admitted on an ACE Inhibitor or Angiotensin II type-1 receptor blockers (ARB).

Clinical practice guidelines issued by both the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research) and the joint committee of the American Heart Association and the American College of Cardiology (AHA/ACC) recommend the use of ACE inhibitors in heart failure patients with significant left ventricular systolic dysfunction. These drugs have now been proven in numerous studies to inhibit the progression of heart failure and reduce mortality. According to data from the Studies of Left Ventricular Dysfunction (SOLVD) trials, even asymptomatic patients with left ventricular systolic dysfunction can benefit from treatment with ACE inhibitors.

ARBs have also been shown in recent trials to provide benefits to heart failure patients similar to those of ACE inhibitors. A potential advantage of ARBs is their greater effectiveness at inhibiting local angiotensin II effects. The preliminary data suggest but have not yet proven the equivalence or superiority to ACEIs.

AHA/ACC Guidelines recommend that all patients presenting with chronic heart failure undergo a diagnostic evaluation to determine the type of cardiac dysfunction, correctable etiologic factors, prognosis, and treatment. Transthoracic doppler, two dimensional echocardiography, is of particular benefit in the evaluation of heart failure patients to assess ventricular mass, chamber size, systolic and diastolic function. This evaluation is essential in differentiating heart failure due to diastolic dysfunction from heart failure due to systolic dysfunction.

SUMMARY

Acute myocardial infarction and congestive heart failure are prevalent conditions in Mississippi associated with significant mortality and morbidity. It is critically important that physicians and hospital staffs work together to implement system and process changes that will facilitate the appropriate, timely evaluation and use of indicated therapies in both AMI and CHF patients. Change, while never easy, can be beneficial when properly motivated, designed and implemented. Physicians can and do make a difference not only in the quality of care given but also in the quality of life lived by their patients. I.Q.H. is encouraging all Mississippi physicians and healthcare facilities to examine their treatment processes for AMI and CHF.

The analyses upon which this article is based were performed under Contract Number 500-96-P510, entitled, A Utilization and Quality Control Peer Review Organization for the State of Mississippi, @ sponsored by the Health Care Financing Administration (HCFA), Department of Health and Human Services. The content does not necessarily reflect the view or policies of the Department of Health and Human Services, nor does mention of trade names, commercial products, or organizations imply endorsement by the U. S. Government. The author assumes full responsibility for the accuracy and completeness of the ideas presented. This article is a direct result of the Health Care Quality Improvement Program initiated by HCFA, which has encouraged identification of quality improvement projects derived from analysis of patterns of care, and therefore, required no special funding on the part of this Contractor. Ideas and contributions to the author concerning experience in engaging with issues presented are welcomed.

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The ABC's of AMI

Michael R. McMullan, M.D., F.A.C.C.

The year is 1950. The United States is still recuperating from World War II. Robert Jones, a 48-year-old executive develops chest tightness one morning before work. The pain does not resolve over several hours, and he finally decides to visit his physician. Dr. Smith performs some blood work and an electrocardiogram. He diagnoses Robert with a heart attack and admits him to the hospital. There, he receives the standard of care, anticoagulation and four weeks of complete bed rest. Robert is off of work completely for three months and never is able to return to his previous level of activity.

Fast forward now to the year 2000, where Robert's grandson, Bob Jones is a 50-year-old salesman. Bob, like his grandfather, awakens one morning with a sensation of severe pressure in his chest. After about 15 minutes of ongoing symptoms, Bob takes an aspirin and has his wife call 911. The ambulance arrives within five minutes, and Bob is transported to the nearest emergency room. There, he is given another aspirin and an EKG is quickly performed which shows an anterior injury pattern. He is given nitroglycerin, oxygen, and intravenous beta-blocker, and then subsequently receives administration of thrombolytic therapy. He soon has complete resolution of his symptoms and return of his EKG to normal. He receives heparin for 48 hours, then undergoes cardiac catheterization with subsequent stent placement in his left anterior descending artery. He is discharged the following day on aspirin, beta-blocker, ACE inhibitor, and an HMG CoA reductase inhibitor. He is advised to follow a Step II AHA diet, begin an exercise regimen, and stop smoking. He returns to part-time work in two weeks and is back to full speed in four weeks.

These two case scenarios, while fictitious, demonstrate the marked advances in the last half of a century in the treatment of cardiovascular disease and prevention of recurrent events. The therapies administered to Bob during his heart attack are the current standard of care, not cutting edge medicine, and are based on the evidence of multiple randomized trials demonstrating their benefits. Unfortunately, based on the data outlined in the article by

Information and Quality Healthcare (I.Q.H.), as well as in multiple other sources of statistical information such as the Cooperative Cardiovascular Project and the National Registry of Myocardial Infarctions I and II, many patients, especially in Mississippi, are not receiving therapies that they are eligible for and deserve.

None of the medications listed above are experimental or revolutionary. In fact, most physicians should be comfortable with the administration of each of these agents, including thrombolytics, and certainly all physicians who staff emergency rooms or work in hospital settings where they are exposed to patients with acute myocardial infarctions should be able to administer these medications appropriately and efficiently. Yet, based on the data, *over one out of every five patients with myocardial infarctions in Mississippi eligible for aspirin never even receive it, as well as over half of the patients eligible for beta-blocker therapy.* This is in stark contrast to the nearly nine out of ten patients receiving these agents in some other states, and far short of a goal that should be nearing 100% since patients who are not eligible for these medications are not included in these statistics.

These facts leave us two questions to answer – first of all, what therapies should our patients experiencing heart attacks expect from us as their physicians, and secondly, what can we do to improve our delivery of care and meet these expectations?

In order to answer the first question, let's utilize the "heart attack Bible", the recently updated ACC/AHA Guidelines for the Management of Patients with Acute Myocardial Infarction. Before we look here for all the answers, we should realize the limitations of the document. First, in today's ever-changing field of medicine, no one source can be considered the complete and final reference, often because the information is out-dated once it hits final print with new discoveries being made on an almost daily basis. Secondly, each patient situation must be individualized, and as much as we would like a cookbook to follow, medicine truly does remain an art form with all answers not being black and white. All of that

having been said, the recommendations outlined in this document are the results of extensive review of the literature and clinical trials by a group of experts in the field and are endorsed by the two largest cardiovascular organizations in the United States. The recommendations are also presented in a format allowing the reader to discern the amount of evidence available supporting a specific therapy so that strategies may be further individualized based on a risk vs. benefit basis.

For patients presenting with ischemic-type chest discomfort, the ACC/AHA recommendations call for immediate administration of 160-325 mg of aspirin as well as performance and interpretation of an EKG within ten minutes of arrival to the emergency room. If a patient truly is aspirin allergic, clopidogrel or ticlopidine may be substituted, but the reasons for doing so should be clearly documented in the medical records. Anti-ischemic therapy should then be initiated, including nitroglycerin, beta-blocker, and probably oxygen, while assessing both the indications and contraindications for thrombolysis. In those patients deemed eligible, thrombolysis should ideally be initiated within 30 minutes of arrival to the emergency room. Certainly, routine lab work as well as cardiac enzymes and a lipid profile should also be drawn on arrival to the emergency room. Unfractionated heparin is considered a Class IIa recommendation (weight of evidence in favor of efficacy) following thrombolysis with fibrin-specific agents such as alteplase or reteplase.

As for the specific recommendations for the major medications used for acute myocardial infarction (and used as quality indicators by I.Q.H.), aspirin 160-325 mg is recommended beginning on day one and continuing *indefinitely* at a dose of 75-325 mg. Beta-blockers should be administered within 12 hours of the onset of infarction and also continued *indefinitely*, i.e. *forever*. ACE inhibitors should be instituted with the first 24 hours of a myocardial infarction and continued *indefinitely* in patients with abnormal left ventricular systolic function and at least six weeks in those with normal systolic function. However, more recent data from the HOPE study would suggest continuing ACE inhibitors *indefinitely* regardless of left ventricular systolic function. Cholesterol abnormalities should be addressed early and treated when appropriate, and aggressive attempts at cessation of smoking should occur in all patients who smoke. Obviously, contraindications exist to each and every one of these medications. However, the medical records should reflect that each of these therapies was considered and should give the reasons that a specific therapy was not utilized.

Now that we know what therapies are recommended,

how can we deliver them more effectively? In order to improve the efficiency of the system and the administration of health care to our patients, we need to focus on four areas. The first is *information*. We must initially take a serious look at gathering the information in each of these categories reflecting our delivery of health care to patients experiencing a myocardial infarction. Each of us looks at these statistics and says, "Other places may be doing this poorly, but that clearly is not the experience in my own practice." Yet, time and again, once the data is analyzed, the results are remarkably consistent. We must be made aware of the problem before we can address it. This is the area in which the role of I.Q.H. is particularly beneficial – garnering the data to inform specific hospitals of where they stand in each category as well as the improvements seen over a period of time.

The second area for improvement is *education*. Physicians, nurses, other hospital personnel, and even patients must be aware of the recommended therapies before they can be put into practice. The checklists supplied by I.Q.H. can also be beneficial in this regard, increasing awareness by listing current recommendations as quality indicators. The third area is in *documentation*. Many times, certain therapies are not instituted for valid reasons that are clear to the physician at the time but not to the people reviewing the medical records due to the lack of documentation regarding the thought process behind the decision. An obvious example of an area where lack of documentation likely plays a major role is in counseling our patients to discontinue smoking but not documenting our recommendations in the chart. Many of the quality indicators would likely be improved with no change in medical care but with better documentation of our current care.

The final area for improving the delivery of health care is *organization*. Too many times, important steps are omitted when performed in a random fashion. Algorithms, such as the sample included at the end of this document, may be helpful. We often avoid them (particularly in academic medicine) because it "inhibits the thought process," but it can be a very good way to ensure that all of the important areas are covered in a complete and efficient pattern. Other suggestions are the implementation of heart attack kits or thrombolytic boxes that can be kept in the emergency room in order to facilitate timely administration of thrombolytics during an acute myocardial infarction. Standardized order forms for admission and discharge of patients with heart attacks may also be helpful in ensuring that all major areas of concern have been covered, and at the same time, assisting in attempts to improve documentation. Multiple areas for improvement

exist, and these often can best be addressed at the local level depending on the specific circumstances surrounding certain problems.

Therefore, utilizing evidence-based medicine, it is clear that *all* patients experiencing an acute myocardial infarction should be considered for aspirin, beta-blockers, timely reperfusion therapy, ACE inhibitors, and appropriate management of cholesterol and smoking status. However, based on the data presented by I.Q.H., it is also clear that we as Mississippi physicians and hospitals have significant room for improvement. With this information, we should strive to make our health care delivery more effective through education of our physicians and hospitals concerning recommended therapies, improved medical documentation, and better organization to ensure that

all appropriate therapies are considered. Our ultimate goal should be one of at least progress if not perfection so that we may better serve our patients as well as our state.

The ABC's of AMI

Aspirin

Beta-blocker

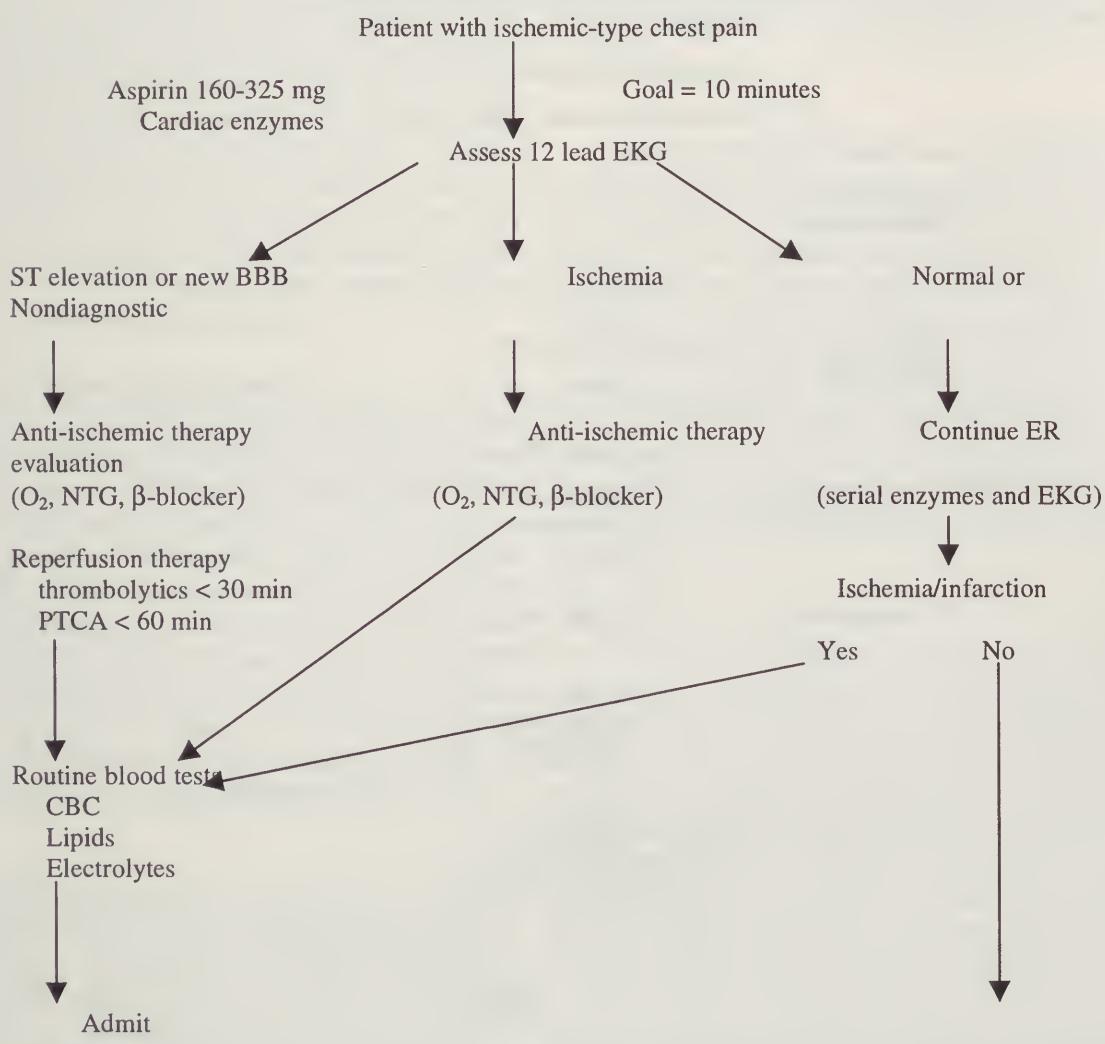
Cholesterol treatment

Discontinuation of smoking

Enzyme (ACE) inhibitors

These are items to consider in every patient who is having a myocardial infarction, whether they are candidates for thrombolytic therapy or not. Medications should be started on day one and continued indefinitely.

Algorithm for Suspected Myocardial Infarction



Adapted from the ACC/AHA Guidelines for the Management of Patients With Acute Myocardial Infarction, 1999 Update

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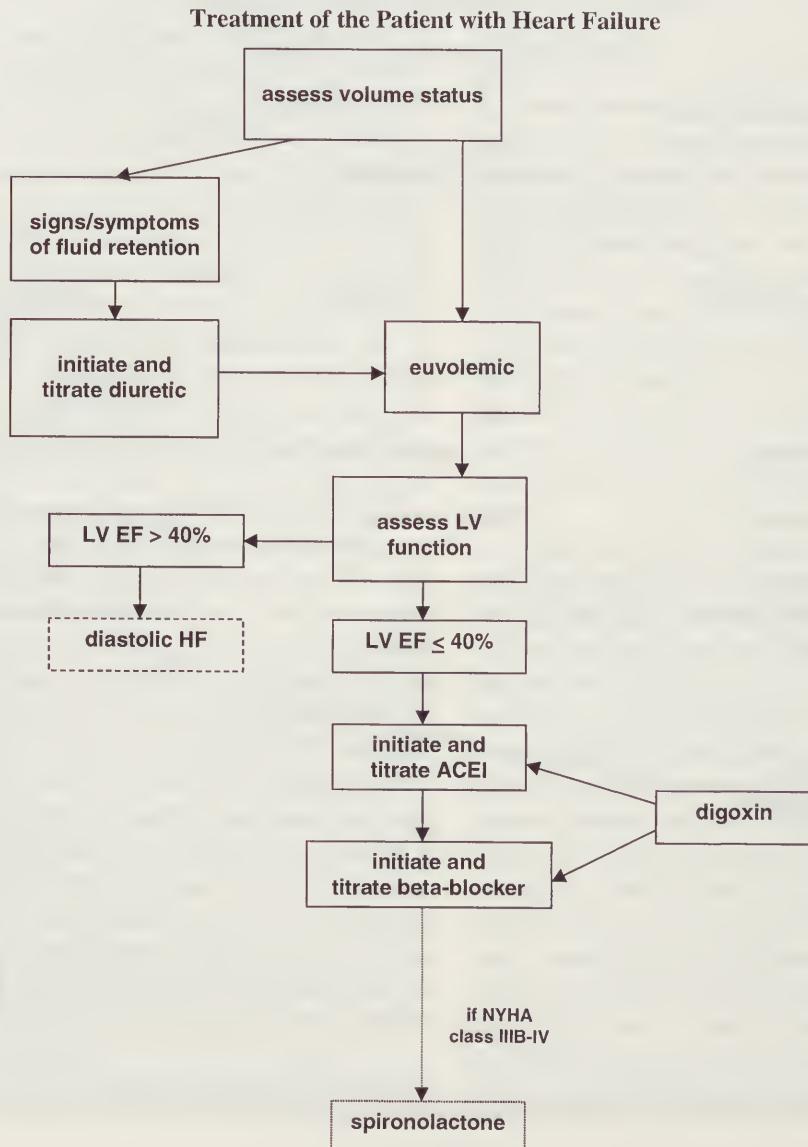
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— Michael R. McMullan, M.D., F.A.C.C.
Assistant Professor of Medicine
Division of Cardiology
University of Mississippi Medical Center

Fig 1.— For adjacent article: "Overview of Current Chronic Heart Failure Therapy.



Overview of Current Chronic Heart Failure Therapy

Charles K. Moore, M.D.

Staggering burdens of hypertension and atherosclerotic coronary artery disease combine to make heart failure (HF) an even greater epidemic in Mississippi than in the United States as a whole. As elsewhere HF is the leading cause for hospitalization in Medicare patients and accounts for massive levels of health care expenditure. Although impressive these statistics only scratch the surface, since they fail to account for the numerous cases where HF is a secondary or co-morbid condition. Unfortunately the prevalence of HF is expected to *double* or *triple* over the next decade. The public health implication is that even small improvements in HF therapeutic practices will have a huge favorable impact when multiplied across the entire affected population.

Current Guidelines for Treatment

HF is a varied clinical syndrome caused by a myriad of underlying cardiovascular diseases (hypertension and coronary artery disease being the leading culprits). The spectrum of HF includes abnormalities in the function of the left ventricle, right ventricle or both, and systolic dysfunction, diastolic dysfunction or both. Although HF due to isolated diastolic dysfunction is relatively common, systolic HF predominates. The bulk of currently available clinical trial data addresses the treatment of HF in patients with left ventricular (LV) ejection fractions (EF) $\leq 40\%$. For these reasons this brief overview will be restricted to the treatment of patients with LV systolic dysfunction.

diuretics

The initial treatment plan in the HF patient requires a clinical assessment of the volume status (see Figure 1, opposite page). The presence of signs or symptoms of fluid retention necessitates the initiation of a diuretic agent, which is then titrated until a euvolemic state is achieved. The type of diuretic used is dependent on the

severity of the HF and the underlying renal function. Most patients with significant congestion require a loop diuretic. Dietary sodium restriction is critical, and helps limit the required dose of the diuretic. Patients lacking any signs or symptoms of congestion need not be treated with a diuretic.

measurement of LV EF

Concurrent with the initiation of diuretic therapy (if needed) plans should be made to assess the LV systolic function, which will dictate further therapy. Most commonly this can be achieved with two-dimensional echocardiography, although other techniques such as radionuclide or contrast ventriculography may also be used. Echocardiography has the advantage of assessing wall thickness, valvular function and chamber sizes and also being non-invasive. Patients with an LV EF $> 40\%$ presumably have diastolic HF and fall outside the scope of these guidelines. Patients with an LV EF $\leq 40\%$ should be started on an angiotensin converting enzyme inhibitor (ACEI).

ACEI's

Convincing clinical trial data have confirmed the pivotal role of ACEI's in the treatment of patients with systolic dysfunction and the entire spectrum of symptomatology — New York Heart Association (NYHA) class I through IV. They have been shown to delay disease progression, relieve symptoms, reduce hospitalizations and improve survival. Although effects on blood pressure, renal function and serum potassium must be monitored, the vast majority of patients can be successfully treated with these agents (greater than 90% of patients in clinical trials). Cough has been reported as an adverse effect in up to 20% of patients with HF on ACEI's in clinical trials, but the most common cause of cough in these patients is, in

fact, HF itself (pulmonary congestion). Studies of patterns of use in the community reveal usage of doses substantially lower than those found to be maximally beneficial in clinical trials. The ACEI should be initiated at a low dose, then sequentially uptitrated to the target dose or the maximally tolerated dose (table 1).

Table 1

Target Doses of Common ACEI's for the Treatment of Heart Failure

captopril	50 mg tid
enalapril	10-20 mg bid
lisinopril	20-40 mg qd
quinapril	20 mg bid
fosinopril	20-40 mg qd
benazepril	20-40 mg qd
trandolapril	4 mg qd
ramipril	5 mg bid

beta-blockers

Although historically contraindicated in patients with HF, overwhelming clinical trial data have now proven that some beta-blockers can prolong life in patients with mild-moderate HF (NYHA class II-III). The magnitude of the beneficial effect actually exceeds that of ACEI's. Favorable results have been obtained in large trials using carvedilol, bisoprolol and metoprolol XL. In addition to mortality reductions, beneficial effects were also demonstrated on symptoms, hospitalizations and LVEF. As with ACEI's these agents must be initiated at a very low dose and slowly uptitrated (generally every 2 weeks) to the target dose or the maximally tolerated dose (table 2). Patients should be stable on therapy with diuretics and ACEI's \pm digoxin before initiating the beta-blocker. Clinical deterioration may occur during titration; symptomatic benefit is usually delayed until after 2-3 months of treatment. Pending additional study results the initiation of

beta-blockers in patients with class IV HF is not routinely recommended.

digoxin

Through the years the proper role of digoxin in the treatment of HF has been controversial. Solid clinical trial data now confirm favorable effects of digoxin on symptoms of HF and rates of hospitalization with a neutral overall effect on survival. The addition of digoxin should be considered in patients with residual NYHA class II-IV symptoms despite optimal therapy with diuretics, ACEI's and beta-blockers. In addition, digoxin is recommended for control of ventricular response in patients with HF and atrial fibrillation, although beta-blockers are usually more effective at controlling the heart rate during exercise.

spironolactone

Recent results from the RALES trial demonstrated a significant reduction in mortality in HF patients with current or recent NYHA class IV symptoms treated with the aldosterone antagonist spironolactone. Low doses (12.5-50 mg daily) should be used, and patients should have normal serum potassium levels (< 5.0 mmol/L) and adequate renal function (serum creatinine < 2.5 mg/dL). At this point it is unknown if the beneficial effects can be extrapolated to HF patients with less severe symptoms.

Opportunities for Improvement

The widespread application of state-of-the-art treatment guidelines to clinical practice has proven difficult in virtually every area of medicine it has been measured. The treatment of HF is no exception, as demonstrated by the baseline data presented by Information and Quality Healthcare (IQH). A portion of the shortfall in performance is likely related to simple deficits in documentation, but improving the remainder will require real change in clinical practices. Measurement of actual clinical practices serves a vital role in illuminating areas of sub-standard performance. Corrective plans can then be implemented and subsequent improvement monitored.

Based on the present body of knowledge, ACEI's and beta-blockers are the only therapies available which favorably alter the natural history of HF in the vast majority of patients (Table 3). Preventing or delaying the progression of HF with these agents is central to reducing the tremendous impact of this syndrome in Mississippi. Therefore, several key strategies can be identified for decreasing morbidity and mortality from HF in Mississippi (Table 4). The quality improvement initiative on HF being implemented in Mississippi by IQH directly addresses two of these three key strategies. Innumerable

Table 2

Dosing of Beta-Blockers for the Treatment of Heart Failure

drug	starting dose	target dose
carvedilol	3.125 mg bid	25-50 mg bid
bisoprolol	1.25 mg qd	10 mg qd
metoprolol XL	12.5 mg qd	200 mg qd

Mississippians will reap the benefits of this initiative and others like it in the years to come.

Table 3

“Disease-Modifying”* Agents for the Treatment of Systolic Heart Failure

1. ACEI's
2. beta-blockers
3. spironolactone (NYHA class IIIB-IV)

* slow progression of disease and/or reduce mortality

Table 4

Key Strategies for Improving Heart Failure Therapy in Mississippi

1. assess LV systolic function (document EF) in every patient
2. maximize usage and dosage of ACEI's*
3. maximize usage of beta-blockers in patients with mild-moderate CHF*

* in patients with LV EF \leq 40%

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— **Charles K. Moore, M.D.**
Assistant Professor of Medicine
Medical Director, Heart Failure / Cardiac
Transplant Programs
University of Mississippi Medical Center

WHEN YOU NEED TO BE SEVERAL PLACES AT ONCE, ISN'T IT A RELIEF TO KNOW YOUR BANK WILL BE THERE, TOO?

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*You know that noise
your heart makes
when you work out?*

IT'S CALLED APPLAUSE.

Think of each beat as your heart's way of cheering you on for staying physically active. Want a standing ovation? Try keeping your diet low in cholesterol and saturated fat too. To learn about other steps you can take toward lowering your risk of heart attack and stroke, visit our web site at www.americanheart.org or call us at 1-800-AHA-USA1.

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Fighting Heart Disease and Stroke

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
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CORONARY CARE 101

Is it too little time, too much involvement with patients, or too much knowledge that makes us as physicians often ignore things that are happening to us. Stop and ask yourself when is the last time that you consulted your personal physician or do you have a personal physician, or do you feel that it is too much of an imposition to ask a colleague to help you when something is going on physically in your life. I always sent my children to their pediatrician and sent my wife to her internist, but I rarely ever sought out my internist and asked him for information regarding my health problems.

Perhaps it was the fact that I was too busy taking care of other patients or the fact that I assumed I could treat all of my own illnesses that I ignored some of the symptoms eventually leading me to have a coronary artery bypass graft. I always felt that my fellow physicians were too busy to worry about some of the symptoms I had and that I, basically being a physician, could take care of myself.

Certainly the old adage holds true that I "had a fool for a physician." I was personally aware of the fact that genetics and lifestyle played a part in coronary artery disease. I was also aware of the fact that on my mother's side I had an aunt and two uncles who had severe coronary artery problems, and another uncle who died at the early age of 40 from coronary artery disease. I was also aware of the fact that my blood cholesterol had always been above 240, no matter how much I tried to diet, and that my LDL had always been above 150 and my HDL in the 30 range, no matter what I did. I also realized that I lived a sedentary lifestyle. I was so busy with the practice of medicine that I had little time for exercise or outside activities, other than those that dealt with the practice of medicine. I also liked to dine on French foods that contained a tremendous amount of butter, cream, and other fatty substances, and I totally ignored the fact that I was about 35 pounds overweight.

Approximately nine to 10 months before my surgical experience, I first noticed some shortness of breath on walking up the stands at football stadiums. I attributed all the shortness of breath and the tightness in my chest to lack of exercise, being overweight, and thought if I would just do some exercise, all of this would leave. In the back of my mind, however, was the thought that perhaps this could be coronary artery disease, but thinking about the treatment of coronary artery disease was frightening enough to make me put that as the last choice and also to think that it never happens to physicians. It was only approximately nine months later when I was on the Gulf Coast with my two boys and tried to walk down the beach while talking to them, and having to stop twice because of tightness in the chest and shortness of breath, and the fact that they kept asking me, "Dad, is something wrong with you?" that I finally realized I had to see my internist.

On arriving back in Vicksburg, I called him and he immediately suggested that I see the cardiologist in our group, Dr. Murray Whitaker, and have a stress test. After talking with Dr. Whitaker, who said this well may not be coronary artery disease, I felt much relieved. However, after taking the stress thallium test, Dr. Whitaker informed me

immediately that I needed to have a cardiac catheterization. I was not surprised but was somewhat frightened when he told me this. I then began to ask him a number of questions about the possibility of dilatation, stenting, etc., and he assured me that these were all possibilities and that if this could be done, it would be done at the time of my cardiac catheterization.

However, on the morning of my cardiac catheterization, although groggy, I was awake enough to realize that most of my disease seemed to be distal and in areas that would be impossible to stent. Almost immediately after the catheterization, Dr. Whitaker confirmed my greatest fear - that I needed to have a coronary artery bypass graft. I talked with my wife about this and she asked me if I wanted to go home and think about it, make a decision, and come back. However, being the obsessive-compulsive person that I am, I immediately said no, that I would like to do it tomorrow, get it over with, and go on with life. The next day I was promptly taken to the operating room and the next thing I remember was waking up in the Intensive Care Unit some hours later with an endotracheal tube, a nasogastric tube, a Foley, and two chest tubes - things that I had put in patients for years but had never really wanted in me. However, as the day wore on I realized how lucky I was to have the tubes in place because I needed those to decompress my stomach, to breathe, to get rid of fluid, and to get the fluid out of my chest.

Twenty-four hours later with the chest tubes clamped, Foley bag in hand, nasogastric tube taken out, and endotracheal tube out, I made my first walk around the Coronary Care Unit and was so happy to get back in bed and just lie down. I only learned after surgery that I had some problems with excessive bleeding. They thought they were going to have to take me back to surgery, but after approximately a dozen or so units of blood, I finally quit bleeding but, because of this, my chest tubes had to stay two days longer than usual. On the third day when my chest tubes were removed, I remember thinking about how patients I had told, "This is not bad but it may sting for a while," and certainly it does. I also remember feeling so thankful to have the Foley because I did not have to get up and urinate as later after liter of fluid came off after being on the extracorporeal circulation system for a while. I was sent to my room on the fourth day, the Foley was removed, and I was allowed to ambulate in the hall with some assistance, and by the morning of the fifth day, I was able to get around by myself, had my IV's out, and was able to take a little P.O. nourishment.

We left the hospital, returned home on the sixth postoperative day, and although extremely weak and sore, I felt that I was gradually coming around until five days later when I suddenly had a severe onset of pain in the middle of the night and had to be taken back to the hospital with a questionable embolus. I was anticoagulated and promptly bled into my chest again, causing atelectasis of the lung, enduring further complications caused by the antibiotics on which I had been placed. With vigorous treatment by Nursing Service, Physical Therapy, Inhalation Therapy, and all of those concerned, I finally was allowed to go home after having my chest retapped seven days later.

This experience certainly enlightened me on a number of things. I now get blood pressure checks and blood lipids done every quarter. I see my internist at least twice a year, have cut my fats down to approximately 35 grams a day, walk two to three and one-half miles every day, and feel better than I have felt in a number of years. I talked with my cardiologist the other day and he suggested that we repeat the stress test after five years unless I had symptoms before then.

At the present time I am doing well and feel that I was very fortunate not to have any muscle damage prior to having my bypass. If I had only known 30 years ago what was in store for me, I think I would have changed my dietary habits, changed my exercise habits, and perhaps, I say perhaps, I could have eliminated a surgical procedure. I am also very thankful that we do have procedures that can correct problems now that will at least give us additional years of life that perhaps in years past we would not have had.

— *W. Briggs Hopson, Jr., M.D.*
MSMA President



W. Briggs Hopson, Jr., M.D. The President's Page

Needs Yet Unfulfilled

In this state approximately 21 to 22 percent of our population is uninsured, these being basically the working class, people who work in small businesses and whose employers have chosen not to buy them health insurance and the young working adults who still have a vision of immortality. Mississippi still continues to have the largest number of people with poor exercise habits, the highest rate of early deaths, and one of the highest infant mortality rates in the country. The list of firsts goes on and on. It is with all of these firsts that the Governor's Health Care Commission was charged, seven years ago, to try and find a solution for health problems in the state. This commission spent approximately five months evaluating the problems and trying to come up with rational solutions. Our conclusions follow. 1) We felt it was critical that comprehensive health care education be addressed, knowing that the benefits would not be immediate but would be of tremendous value in the lifetimes of our children and grandchildren. 2) Tort Reform was needed in order to decrease the cost of defensive medicine and reduce the overall cost of medical care. 3) We developed a plan for provider and consumer alliances to develop a new agency, the Health Finance Authority, which would utilize existing funding to develop a multilevel insurance plan to maintain the affordability of insurance and increase the number of people covered within the state today. Although suggested by a number of legislators and proposed by the governor, very few of these initiatives have been enacted over the past seven years. A few of these have been partially done. However, the one critical issue that we must continue to push for is the education of our children K-12 on preventative health care. This not only includes health education; but, it also includes physical education. In order to have a healthy Mississippi, we must promote and teach children to exercise well, to eat well, and to know what really constitutes a healthy lifestyle. Our new governor and lieutenant governor, as well as our legislative members, are promoting education this year. I therefore challenge each of you to become active in talking with your legislators and your patients about this critical issue. You as physicians must be proactive in unlocking the doors of ignorance and challenging the minds of our youth to become healthier citizens of this state.

In closing, let me again ask you to mark your calendars and plan to attend your Mississippi State Medical Association annual meeting at the Beau Rivage on May 19-21. Please meet with your fellow physicians to discuss issues and voice your opinion on how we can make our organization stronger.

A handwritten signature in black ink, appearing to read "Briggs Hopson".

**MISSISSIPPI STATE HOSPITAL OPENS A MUSEUM:
A HISTORY OF THE TREATMENT OF MENTAL ILLNESS IN MISSISSIPPI**

"Meditation in Hydrotherapy"

*Six hours a day I lay me down
Within this tub but cannot drown.*

*The ice cap at my rigid neck
Has served to keep me with the quick.*

*This water, heated like my blood,
Refits me for the true and good.*

*Within this primal element
The flesh is willing to repent.*

*I do not laugh; I do not cry;
I'm sweating out the will to die.*

*My past is sliding down the drain;
I soon will be myself again.*

—Theodore Roethke (1908-1963)

Dorothea Lynde Dix, a Boston schoolteacher, would become known as the "Angel of Mercy" for her social activism on the part of the mentally ill. Her visits to the state in the 1850s crystallized support for the State Lunatic Asylum.



Roethke's intimate poetic glimpse of early twentieth century psychiatric medicine is painted on one of the marble walls of the newly opened Mississippi State Hospital Museum, an outstanding contribution for public understanding of the history of the treatment of mental illness in Mississippi. This excellent and instructive museum is located deep within the bowels of "Building 23," which was originally the receiving building for white males, constructed in 1929. State-of-the-art features were placed in the building when constructed, including the hydrotherapy rooms in the basement, which make up the most fascinating aspect of the museum.

The modern treatment of mental illness in Mississippi dates back to antebellum times. Social activist Dorothea Lynde Dix, the Boston schoolteacher nationally known as a mental health reformer, made two trips to Mississippi and her activism proved instrumental in the erection of the first mental institution in the state. Following the creation of an

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

institute for the blind in 1848 and an institution for the deaf in 1854, the state legislature evidenced a progressive approach to those medically afflicted and unfortunate, and was ripe for Dix's message. When established in 1855 (although building commenced earlier), the institution was called the "State Lunatic Asylum," and it was one of just a few mental asylums in the country. The Jackson asylum, located on the present site of the University of Mississippi Medical Center, survived the Civil War, tornadoes, fires, and shifting Yazoo clay. The central building, with columns and a cupola, would have wing after wing added on to its old sides, stretching out like a prehistoric bird on the outskirts of early Jackson. It provided care for thousands of Mississippi's mentally ill. In March of 1935, after 80 years of use, the hospital was moved to its present site at Whitfield, which included 3800 acres of state-owned land in Rankin County. The new site was a move to a more isolated and pastoral environment, and based on "cottage-type model," a modern prototype very different than the interconnected wards of the old asylum. (Ironically, the Whitfield area had witnessed earlier medical history, for this was where Dr. Joseph Goldberger did his research identifying the nutritional deficiencies which caused pellagra.)



The State Insane Asylum, from a turn of the century photograph, had a central building with marble columns and classic front, crowned by a cupola. Wings went off left and right from the main building. The Asylum remained in Jackson from 1855 to 1935. The asylum was located on the present site of University Medical Center.

A brochure states that the museum's purpose is "to supplement the hospital's community education program to increase public awareness about mental illness, the first approaches in treatment modalities, and the evolution of our understanding of the disease." The museum succeeds grandly. It offers a concise historical overview of the treatment of mental illness from the founding of the Mississippi State Hospital in 1855 to the present time, centering on the critical role that the Mississippi State Hospital, originally the Mississippi State Lunatic Asylum, has played in that treatment.

At the museum's entrance is a television which plays a videotape of past Governor William Winter narrating a brief introduction to the museum. Close by is the dedication of the museum to "all those who have suffered from mental disorders, to their families, and to all those who have cared for them in their battle against these illnesses." Besides the dedication, framed at the entrance, is N. W. Overstreet's architectural drawing of the campus of the "New Mississippi State Insane Hospital," although when the hospital opened in 1935 it dropped "Insane" from its name. Overstreet's vision for the campus endures in the largely unchanged structures and design. In the wrought iron design over the entrance to "Building 23" is an "O" with an "S" inside, Overstreet's subtle architectural signature.

Noteworthy in the architectural designs, besides the endurance of its general plan, is the racial and sexual segregation of the campus. The original asylum in Jackson had both blacks and whites, and while the races were housed in the same building, they were isolated from each other. The new campus at Whitfield consisted of many cottages, and



This tub is located just to the right of the needle spray shower in the old hydrotherapy rooms. Museum officials do not know its use. Do you? If so, contact the public relations department at the state hospital or call the journal's managing editor.

the original plan included two segregated campuses. The western side of the main campus was for black (then termed "colored") residents, and the eastern side for whites. There were four receiving hospitals, with each serving patients of a different gender and race. Each was classified as "white male," "colored male," "white female," or "colored female." Black nurses and attendants were hired to care for the black patients, as white nurses were hired for the "white campus." The campus would remain segregated until after the passage of the Civil Rights Act of 1964, when administrator William L. Jaquith desegregated the campus uneventfully.

The other noteworthy aspect of the architecture of the campus is the endurance of the cupola as the hospital's symbol. The Jackson asylum's central building was crowned with a cupola, and a cupola adorns the main structures at the new hospital at Whitfield.

After one views the video presentation, the museum continues in a large room with archival photographs and other artifacts on display. The photos include images of



"Building 23," the original white male receiving hospital, now provides child and adolescent psychiatric services. The State Hospital Museum is located in the basement with the hydrotherapy equipment.

MISSISSIPPI STATE HOSPITAL Museum



N. W. Overstreet's original architectural drawings of the new State Hospital at Whitfield introduce one to the museum.

Dorothea Dix, the old asylum, and other individuals and buildings of importance at both the Jackson and Whitfield sites. The printed commentary accompanying the photos and artifacts is well written and informative. The museum houses the marble cornerstone of the original building in Jackson, which states: "Mississippi Lunatic Asylum, erected A. D. 1851."

On display under a glass case is a 1904 Registry of Admissions, which includes names of patients, with their admission and discharge diagnoses. Many of the diagnoses included: "Softening of the brain," "chronic and



Above: Here is a marble fever box for the treatment of syphilitic dementia in the 1940s. These boxes were also termed "diathermy cabinets" and "syphilis boxes."

Right: Here is an intact needle spray shower, which created a forceful spray felt to relax and calm the patients.



acute melancholy," "chronic and acute mania," "Acute Bright's," "Acute Dysentery," "Consumption," and "Senile Decay." These diagnoses underscore that mental illness was as much a medical symptom as a psychiatric one, and that the hospital treated not only the mentally ill, but the medically ill, with syphilis, tuberculosis, heart and renal failure dominating the causes of mental illness at that time. The old term "eloped" stands out on the page, and the term, meaning to leave the institution without permission, endures at the hospital today.

The museum rightly recognizes the contributions of Dr. William "Jake" L. Jaquith to the State Hospital and to the modern treatment of psychiatric illness in the state. He is credited with transforming the hospital into the medical model in its approach to mental illness. The Vicksburg native began his service to the hospital in 1947.

He continued his passionate and outspoken fight for Mississippi's mentally ill into the late 1970s.

The other aspect of the museum, perhaps its most fascinating aspect, is old psychiatric treatment rooms located across the hall from the formal museum. That the old hydrotherapy rooms were salvaged intact is a tribute to the vision of the hospital's leaders and supporters. The Mississippi Legislature appropriated funding in the early 1990s to renovate "Building 23" for child and adolescent psychiatric services. As a part of this renovation, plans were made for the creation of a museum in the basement with the hydrotherapy equipment and several additional rooms. The old hydrotherapy rooms are remarkably preserved. There is a marble fever box for the treatment of syphilitic dementia in the 1940s. These boxes were also termed "diathermy cabinets" and "syphilis boxes." Be-

sides the fever box, malaria therapy was utilized, which involved the injection of blood from a malaria patient into the demented patient, to induce fever. There is a needle spray shower, which created a forceful spray felt to relax and calm the patients. Other treatments utilized and represented in the hydrotherapy rooms are wet pack treatments, prolonged warm baths for sedation, electroshock therapy, chemical shock, and psychosurgery. Adding to these exhibits are archival photographs of patients receiving treatment from the very equipment restored in the room.

A beautiful central point at the museum is a WPA era black and white photograph by celebrated Mississippi author Eudora Welty. Her photo is one of many she took of the "old lunatic asylum" while employed in the 1930s by the Works Progress Administration as junior publicity agent. It is a view of the old, decaying cupola in Jackson emerging behind an overgrown field and tall cedars. Welty's artistic presence at the "Whitfield" institution is palpable as well; Masterpiece Theatre is filming Welty's *The Ponder Heart* this spring, and the film crews plan to film a scene in which Uncle Daniel is taken to "Whitfield Asylum" in a Studebaker at the Hospital's Administrative Building.

A dedication and ribbon cutting occurred at the museum on February 17, 2000, and the museum is currently open for tours, but by appointment only, Tuesday and Thursday, 9 a. m. to 12 noon. The museum contributes significantly to our understanding of the history of mental illness, and underscores the need for a broader state medical museum. The State Hospital and its supporters deserve our thanks for creating this outstanding museum. For more information contact the public relations department at the State Hospital at 601-351-8018.

—Lucius Lampton, MD
Associate Editor

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To Enter, contact your local Foundation chair or just fill out the below information and send your check for \$100 made payable to the MSMAA to:
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Nina Bess Goss-Moffitt Full Tuition Scholarship in Medicine Established



Dr. Ellis M. Moffitt of Jackson, seated at center, has established a scholarship in the School of Medicine at the University of Mississippi Medical Center in memory of his wife, Dr. Nina Bess Goss-Moffitt. Designated for a female, the scholarship will be awarded for the first time this fall. Seated with Dr. Moffitt are his children, Dr. Virginia Ellen Moffitt-Crawford of Hattiesburg (at left) and Dr. John E. Moffitt of Jackson (at right). Standing is Dr. Wallace Conerly, Medical Center vice chancellor for health affairs and dean of the School of Medicine.

Dr. Ellis M. Moffitt has established a scholarship at University of Mississippi Medical Center (UMC) in memory of his wife, Dr. Nina Bess Goss-Moffitt.

The Nina Bess Goss-Moffitt Scholarship in Medicine, which is designated for a female, covers full tuition in the School of Medicine. Tuition is currently \$6,838 a year for state residents.

"Scholarships are our greatest need," said Dr. Wallace Conerly, vice chancellor for health affairs and dean of the School of Medicine. "We're deeply honored that Dr. Moffitt chose the Medical Center for this permanent memorial to his wife who served on our faculty for

many years."

A native of Brookhaven, Dr. Goss-Moffitt attended Belhaven College and earned her baccalaureate degree at Millsaps College in 1946 and her M.D. at the Tulane University School of Medicine in 1950. She interned at St. Elizabeth Hospital in Washington, D.C.. She took residency training in psychiatry at the University of Louisville Hospitals in Louisville, Kentucky, where she was chief resident in 1964, and at the UMC. Dr. Goss-Moffitt first joined the Medical Center faculty as a clinical instructor in psychiatry in 1966. When she retired from practice in 1991, she was serving on the full-time faculty as an

associate professor of psychiatry and human behavior.

Dr. Goss-Moffitt was a member of a number of professional organizations, including the American Psychiatric Association and the Mississippi Foundation for Medical Care Board of Directors and Executive Committee. For the latter organization, she also served as chairman of the Long-term Care Committee for the Mentally Retarded for several years.

Listed in Who's Who in America as well and the International Women Who's Who, she was a physician who gave freely of her time as a volunteer. She served as president of the Mental Health Association of the Capital Area, on the Mississippi State Mental Health Department State Planning Advisory Committee, as a member of the Mental Health Commission, as chairperson for the Hinds County Mental Health Commission and associate medical director of the Mississippi State Medical Association's Impaired Physician's program.

The Caduceus Club of Mississippi recognized her

for work with the MSMA Impaired Physicians Program in 1992, and in 1993 she received special recognition for her outstanding work with impaired professionals from the Mississippi State Medical Association. She died on May 3, 1998, leaving her husband and their two children, Dr. John Ellis Moffitt and Dr. Virginia Ellen Moffitt-Crawford, both UMC alumni, and five grandchildren.

The first Goss-Moffitt Scholarship will be awarded in fall, 2000. One new scholarship will be awarded in each of the three following years so that by fall, 2004, there will be four UMC medical students with Goss-Moffitt Scholarships.

Recipients will be selected by the School of Medicine's Committee on Academic Awards using two criteria: need and potential for successful completion of the four-year curriculum. Recipients will receive the Goss-Moffitt Scholarship each year they are in medical school if they remain in good academic standing.



Well underway, Medical Assurance Company of Mississippi officially broke ground to begin construction of its new headquarters located on the Highland Colony Parkway (behind MSMA) in Ridgeland on November 18, 1999. Medical Assurance Company of Mississippi (MACM) is the leading writer of professional liability insurance for Mississippi physicians. Pictured (left to right) are : Linda Thigpen with the Ridgeland Chamber of Commerce; State Senator Walter Michel; Mike Houpt, MACM Chief Executive Officer; Madison County Supervisor David Richardson; Dr. Faser Triplett, MACM President; Ridgeland Mayor Gene McGee; Dr. George Ball, MACM Secretary-Treasurer and Ridgeland Alderman Ann Hurd.

Letter

February 23, 2000

Ms. Karen A. Evers, Managing Editor
Journal of the Mississippi State Medical Association
P. O. Box 2548
Ridgeland, MS 39158-2548

Dear Ms. Evers:

Thank you very much for the very fine article in the Update. The article was very informative, and I believe that many physicians will learn much about this special kind of caring through reading the information contained in this article.

There is one correction that I think must be made. On page 453, in the last paragraph the following is stated:

“..... When I told him that registered nurses visit at least twice a day,.....”

I meant to say in the information I wrote that “registered nurses visit at least twice a week.....” A clarification is needed because I do not want unrealistic expectations to develop. Of course, registered nurses are available to visit whenever needed, and there may be some hospices whose nurses visit at least two times a week and as needed. Our own standard is that registered nurses visit at least two times a week and as needed unless specifically requested by the patient and/or family to limit visits to once a week.

Again, thank you very much for your assistance in spreading the word about Hospice and the services we provide to patients and families who are experiencing terminal illness. I really feel more hopeful today than ever before that finally the very special needs of these patients and families may soon be more realistically identified and more effectively addressed than ever before.

Sincerely,

Mary H. Nichols
Director, Baptist Memorial Hospice and Home Care
Columbus, MS

MSMA

132nd

Annual Session

May 19-21, 2000

**MACM Golf
Tournament: May 18**



Biloxi, Mississippi

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your reservations?**

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GENERAL INFORMATION

REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in references committee meetings as policies of the Association are established. All meetings will be held consecutively.

The schedule is as follows:

2:00 PM	Reference Committee on Constitution and Bylaws
2:30 PM	Reference Committee A
4:00 PM	Reference Committee B

CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours for this session will be listed in the official program of the 132nd Annual Session.

MACM GOLF TOURNAMENT

Medical Assurance Company of Mississippi will reinstate the tradition of sponsoring its annual golf tournament. The tournament will be held at Great Southern Golf Club, 1:00 PM., Thursday, May 18. Prizes will be awarded.

Members and their spouses are invited to all social events which are all complimentary except the **President's Inaugural Celebration** (Black Tie Optional), to which tickets may be purchased at a nominal charge to offset costs.

THE PRESIDENT'S RECEPTION

The annual **President's Reception** will be held Friday evening, May 19, on the Beau Rivage Special Events Deck overlooking the Gulf, from 6:30 P.M. to 8:30 P.M. Enjoy the "Rhythm of The Islands" with steel drum music performed by David Wahl. Since their inception in 1987, *The Tropical Steel Band* has been one of the most truly innovative and entertaining musical groups along the Gulf Coast. Following the reception, guests are invited to an ice cream social sponsored by Southern Medical Association.

MSMA PRESIDENT'S INAUGURAL CELEBRATION AND MSMA ALLIANCE SILENT AUCTION

With the beginning of new Millennium, MSMA will initiate a new practice of conducting the President-elect's Inauguration on Saturday evening, rather than during the closing session of the House of Delegates on Sunday morning. This very special dinner/dance event, which will be black tie optional, will include the inauguration of Dr. Candace Keller as MSMA's 133rd President, special recognition of MSMA's component society Presidents, the MSMA Alliance's annual Silent Auction to benefit the AMA Foundation, and entertainment by several celebrity guests performers. All MSMA and MSMA Alliance members will receive an invitation and information about purchasing tickets for this memorable and fun evening.

COMPONENT SOCIETY CAUCUSES

If your component society plans to hold a caucus you need to reserve a location a.s.a.p. Planning for meeting rooms has already occurred and there is limited space for small groups.

MSMA 132nd Annual Session and Scientific Assembly
May 18-21, 2000
Beau Rivage • Biloxi, MS • 1-888-567-6667

PRELIMINARY SCHEDULE

THURSDAY, MAY 18

11:00 a.m. Executive Planning Group Benefit Lunch Meeting
1:00 p.m. Registration
MACM Golf Tournament
2:00 p.m. Exhibitor set-up
4:00 p.m. Board of Trustees Meeting

FRIDAY, MAY 19

7:30 a.m. Continental Breakfast with Exhibitors
(Sponsored by Horne CPA Group)
MS Eye, Ear, Nose & Throat Association
Breakfast
8:00 a.m. Registration
Reference Committee Orientation
9:00 a.m. House of Delegates
11:00 a.m. Lunch with Exhibitors
Alliance Pre-Convention Lunch Meeting
Mississippi Association of Public Health
Physicians Meeting
11:30 p.m. Board of Trustees Meeting
MMPAC Membership Meeting
Young Physician's Section (YPS) Business
Meeting
Information & Quality Healthcare (I.Q.H.)
Annual Meeting
2:00 p.m. Reference Committee on Constitution and
Bylaws
Reference Committee A
4:00 p.m. Reference Committee B
6:30 p.m. President's Reception
9:00 p.m. Southern Medical Association Coffee and
Dessert Party

SATURDAY, MAY 20

7:00 a.m. Specialty Society Breakfast:
Mississippi Section of the
American College of
Obstetricians and Gynecologists
7:30 a.m. Registration

7:30 a.m. Continental Breakfast with Exhibitors
Board of Trustees Meeting
Specialty Society Breakfast:
MS Chapter of the American
College of Surgeons
Past President's Breakfast
Fifty-Year Club Breakfast
8:30 a.m. Plenary Session
Alliance Welcome and Coffee
9:00 a.m. Alliance House of Delegates Meeting
MS State Dermatology Society Meeting
11:00 a.m. Alliance Luncheon / Installation of
Officers
11:30 a.m. Committee on Publications Lunch Meeting
MPCN Board of Directors Meeting
Specialty Society Luncheons:
MS Chapter of the ACEP
MS Academy of Family Physicians
MS Chapter of the American College
of Surgeons
MS State Dermatology Society
Women in Medicine Lunch Meeting
1:00 p.m. Plenary Session
Preview Art for AMA Foundation Auction
4:00 p.m. Component Society Caucuses
Central Medical
Coast Counties
Singing River
5:30 p.m. University of MS Alumni Reception
6:30 p.m. MSMA President's Inaugural Celebration
MSMA/MSMA Alliance Reception and
AMA Foundation Silent Auction

SUNDAY, MAY 21

7:00 a.m. Board of Trustees Meeting
7:30 a.m. Registration
Continental Breakfast for Members
8:00 a.m. Worship Services
8:30 a.m. Alliance Past-Presidents' Breakfast
9:00 a.m. House of Delegates
11:30 a.m. Board of Trustees Meeting
12 noon Board of Trustees Luncheon

“MEDICAL AFFAIRS FORUM 2000”

(PRELIMINARY PLENARY SESSION SCHEDULE)

SATURDAY, MAY 20 • MAGNOLIA BALLROOM

8:30 A.M. “RISK MANAGEMENT”

- Whitman B. Johnson, III, Esq.

Currie, Johnson, Griffin, Gaines & Myers

Sponsored by the Medical Assurance Company of Mississippi
(MACM)

9:45 A.M. “MEDICAL STAFF BY-LAWS: THE GOOD, THE BAD AND THE UGLY”

- Anne M. Murphy, JD, Vice President,

Health Law Division,

American Medical Association

11:30 A.M. LUNCH BREAK

1:00 A.M. “HEALTH CARE LEGISLATION AND THE 107TH CONGRESS”

- Mr. Julius Hobson, Director of Congressional Affairs,
American Medical Association

**2:00 P.M. “CHEMICAL IMPAIRMENT AND THE MISSISSIPPI RECOVERING PHYSICIANS PROGRAM”
(MRPP)**

- Gary Carr, M.D., Medical Director,
Mississippi Recovering Physicians Program

- C. Chapman Sledge, M.D., Medical Director,
Pine Grove Recovery Center

**3:00 P.M. “OPHTHALMOLOGY UPDATE: LASIK (LASER EYE SURGERY) AND
INTACS (CORNEA RING IMPLANT SURGERY”**

- Connie McCaa, M.D., Director of Corneal Services
Professor, School of Medicine
University of Mississippi (UMC) Medical Center

- Robert A. Mallette, M.D.

4:00 P.M. ADJOURN

**PLENARY PROGRAMS PLANNED BY MSMA's:
COUNCIL ON SCIENTIFIC ASSEMBLY**

TECHNICAL EXHIBITS

MSMA 132nd Annual Session

EXHIBITORS

(as of JOURNAL MSMA Press Date)

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Coastal Insurance Enterprises, Inc.

Doctors Insurance Reciprocal

Executive Planning Group

Health Link

Information & Quality Healthcare (I.Q.H.)

Medical Assurance Company of Mississippi

Merck Human Health Division

Mississippi Physicians Care Network

MS State Department of Health

MSMA Benefit Plan& Trust

Pfizer, Inc.

UAB Health System

United HealthCare



Mississippi State Medical Association Alliance

77th Annual Session
May 18-21, 2000
Beau Rivage Resort
Biloxi, MS

THURSDAY, MAY 18

1:00 PM - 4:00 PM Registration

FRIDAY, MAY 19

8:00 AM - NOON Registration
11:00 AM Pre-convention Board Meeting/Luncheon
6:30 PM MSMA President's Reception

SATURDAY, MAY 20

8:30 AM Alliance Welcome and Coffee
9:00 AM House of Delegates
11:30 AM Luncheon/ Installation of Officers
2:00 PM Post-convention Board Meeting
6:30 PM MSMA/ MSMAA Membership Reception
& AMA Foundation Auction
MSMA President's Inaugural Celebration

SUNDAY, MAY 21

8:30 AM MSMAA Past Presidents' Breakfast

Placement / Classified Service

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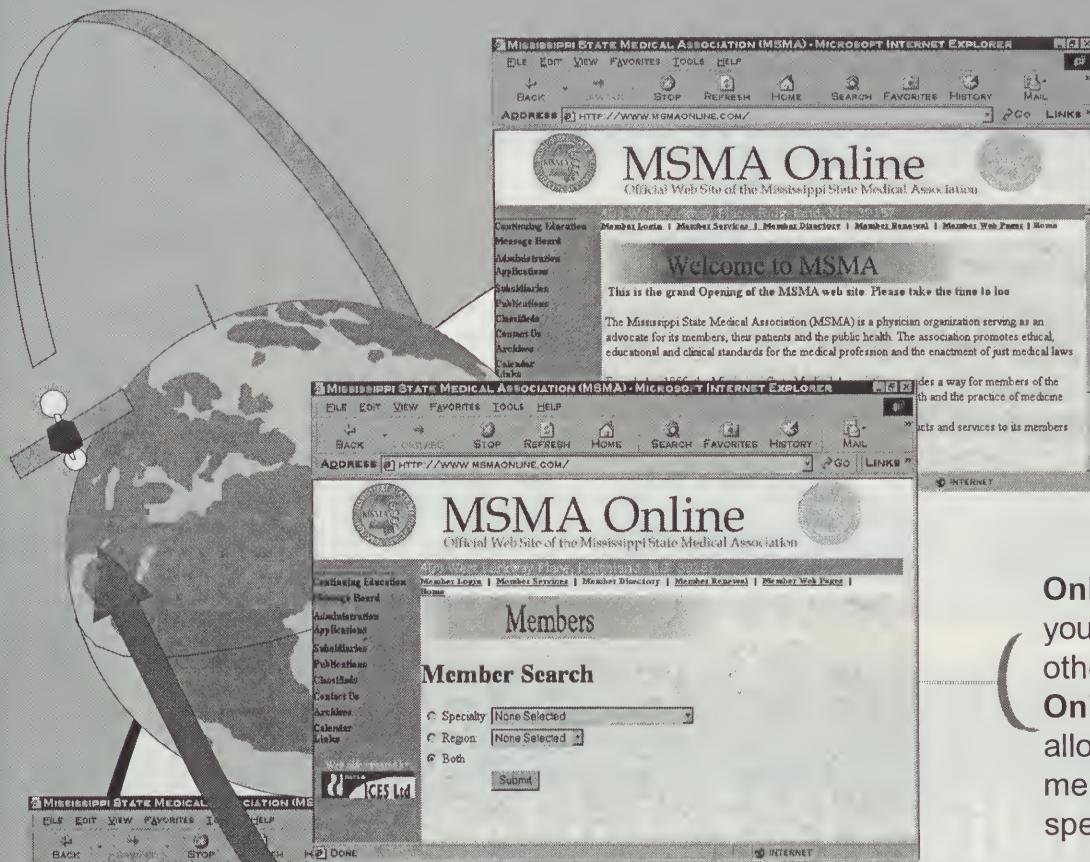
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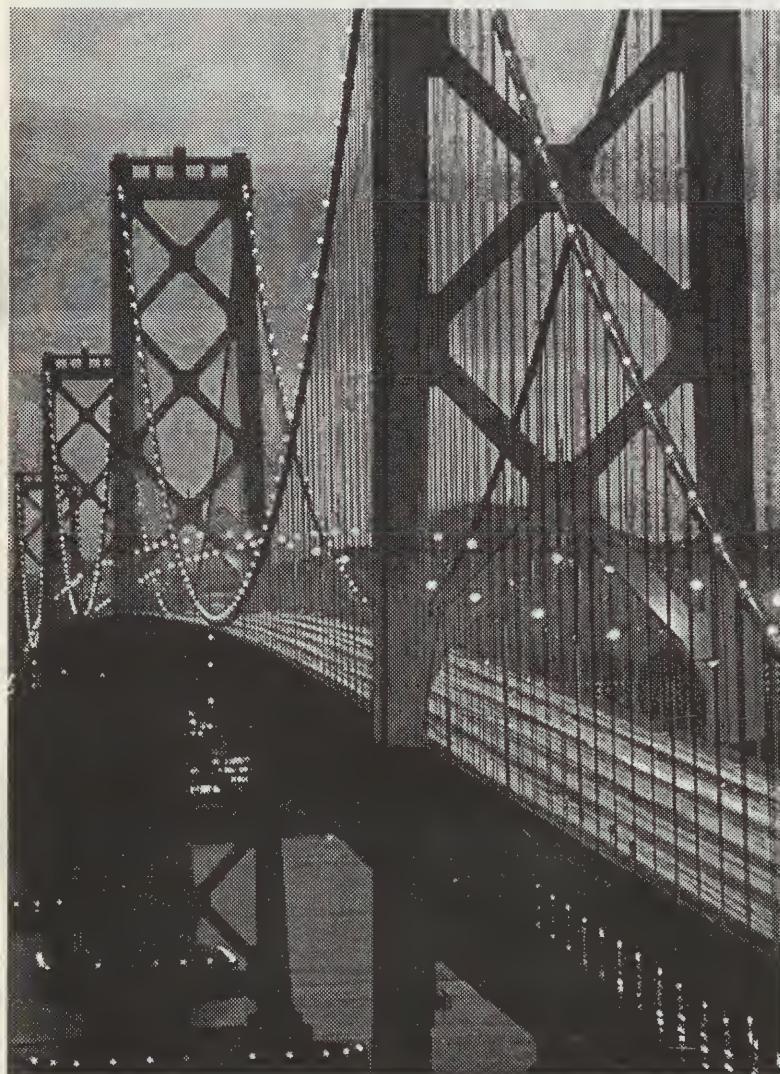
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JOURNAL
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MAY 2000 VOLUME XLI NUMBER 5



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September 13 - 17, 2000

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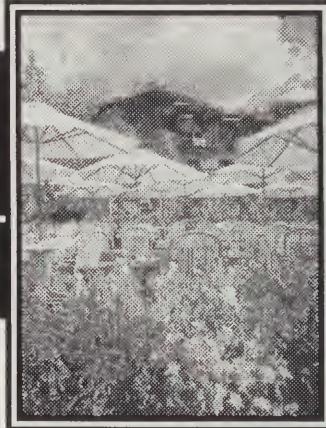
Course Objective: A multi-specialty conference designed to cover a broad range of oncology-related topics providing information on early detection, medical and surgical options, treatment and complications associated with cancer.

Intended Audience: Primary Care Physicians and Physicians in all Specialties

Course Director:
Gerry Ann Houston, MD

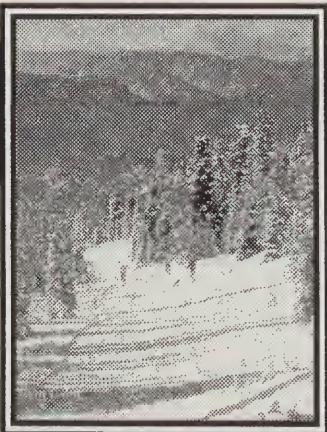
Group Events: Welcome Reception, Group Dining and Dancing at Larkspur Restaurant

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Costs: Physician Rate: \$1,580.00
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Rate Includes: Conference Registration, Roundtrip Airfare from Jackson, MS to Denver, CO, Transfers to Vail, CO, Four Nights Accommodations, Daily Breakfast, Taxes and Gratuities



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Intended Audience: Primary Care Physicians and Physicians in all Specialties

Course Director: Eric A. McVey, MD

Group Events: Welcome Reception, Group Dinner

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2001 Multi-Specialty Physician Conference • February 8-12

Noninvasive Estimation of the End Systolic Pressure-Volume Relationship Using Impedance Cardiography

Richard L. Summers, MD

A bstract

PURPOSE: Traditional measures of cardiac contractility such as dp/dt and ejection fraction has been noted to be sensitive to preload and afterload conditions. The end systolic pressure-volume relationship of the left ventricle (ESPVR, Suga Index or Emax) has been found to be the best load independent measure of the cardiac contractile state. However, determination of the ESPVR requires very highly invasive procedures. Impedance cardiography (IC) is a reliable noninvasive method for calculating stroke volume and may also be useful for estimating the end systolic volume.

METHODS: An equation was derived using the systolic time intervals (PEP = pre-ejection period, LVET = left ventricular ejection time) and determined stroke volume (SV) as calculated from the impedance cardiograph to estimate the end systolic volume of the left ventricle. Likewise, end systolic pressure (ESP) was estimated from brachial cuff pressures using a previously published method. The resulting ESPVR was then calculated from tracings recorded in healthy normal subjects and compared to those obtained from patients in decompensated congestive heart failure (ejection fraction $< 30\%$ by echocardiogram) using the standard t test ($p < 0.05$).

RESULTS: Using the derived equation ($ESPVR = ESP/(SV/(1.125-1.25(PEP/LVET)) - SV)$), the ESPVR for the normal group of 6 averaged 2.72 ± 0.71 and was significantly different from the 1.04 ± 0.45 found in 6 patients with known systolic dysfunction. In a further test of the method, 15 patients who received concurrent echocardiographic and IC evaluations were found to have calculated ESPVR values that significantly correlated with determined ejection fractions ($r = 0.83$, $p < 0.01$).

CONCLUSIONS: A noninvasive method for estimating the ESPVR that differentiates the myocardial contractile state in the clinically setting was derived using parameters obtained from IC. While further studies are needed to correlate this new equation with invasive measurements, this method has the potential for easily estimating load independent contractility in patients with cardiac dysfunction.

Key Words: contractility, end systolic pressure-volume relationship, impedance cardiography

Introduction

The determination of the myocardial contractility is vital in the assessment of the hemodynamic condition of critically ill patients. Traditional noninvasive measures of cardiac contractility such as dp/dt and ejection fraction have been noted to be highly sensitive to preload and afterload conditions (peripheral vascular resistance and arterial and venous pressures). The end systolic pressure-volume relationship of the left ventricle (ESPVR, Suga Index or Emax) is the slope of the line relating the intraventricular volume and pressure at the end of systole and has been found to be the best load independent measure of the cardiac contractile state.^{1,2} However, the true determination of the ESPVR requires left heart catheterization or other highly invasive procedures to measure the end-systolic pressure and volume. These methods are often not practical in the evaluation of acute patient presentations and there is some concern among the medical community of the inherent morbidity and mortality associated with these invasive techniques.

Impedance cardiography (IC) has been found to be a reliable noninvasive method for calculating stroke volume and estimating the ejection fraction and therefore may also be useful for estimating the end-systolic volume (3,4). When IC calculated values are combined with previously determined noninvasive methods for estimating end-systolic pressure, it is possible to derive a relationship that should accurately estimate the ESPVR by completely noninvasive means (5). In this study a procedure for noninvasively determining the ESPVR is presented and compared to measures of contractility obtained from echocardiography performed on patients with varying degrees of cardiac dysfunction.

Theory

TEB monitoring was first developed by NASA in the 1960's to measure the effect of microgravity on the circulatory dynamics of astronauts (6). Since that time it has been used primarily for continuous cardiac output monitoring in critical care patients. (7,8,9,10). However, along with stroke volume determination, IC can also be used to calculate systolic time intervals and provides an accurate estimation of the cardiac ejection fraction (4,11,12,13). The primary deflection of the bioimpedance waveform coupled with electrocardiographic information has been correlated with the systolic time intervals by phonocardiogram (11). Regression formulas using the PEP/LVET ratio (PEP=pre-ejection period, LVET=left ventricular ejection time) are used to noninvasively predict the ejection fraction and have been strongly correlated with findings from echocardiography and ventriculography (4,13). Ejection fraction calculation by the Weissler method is the oldest and most frequently used of these formulas (EF = 1.125 – 1.25 * (PEP/LVET)); where EF=ejection fraction, PEP=pre-ejection period, LVET=left ventricular ejection time) (14).

The end systolic pressure (ESP) is estimated using a previously published method in which a mathematical relation is derived from the values of systolic (SP) and diastolic (DP) brachial cuff pressures (ESP = ((SP-DP)/3) + DP) (15). This relationship has been found to be consistent with those values obtained from invasive means and has been used with ventriculography to accurately estimate the completely invasive measure of the ESPVR.

Since the ejection fraction represents the portion of the diastolic volume that is ejected during systole, then it follows that the systolic time intervals (PEP=pre-ejection period, LVET=left ventricular ejection time) and determined stroke volume (SV) as calculated from the impedance cardiograph can be used to estimate the end systolic volume of the left ventricle. The relationship for deter-

mining the ESPVR then becomes:

$$\text{ESPVR} = \text{ESP}/(\text{SV}/(1.125-1.25(\text{PEP}/\text{LVET})) - \text{SV}$$

While the separate parts of this relation have been validated with invasive measures, it is important that values obtained from use of the whole expression are also tested for relative accuracy. Ejection fractions obtained by echocardiography, the current noninvasive gold standard measure of contractility, were used as a benchmark for comparison.

Methods

An equation was derived as described using the systolic time intervals (PEP, LVET) and determined stroke volume (SV) as calculated from the impedance cardiograph to estimate the end systolic volume of the left ventricle. The records of patients in which IC was used as a part of their clinical evaluation were analyzed for the presence of concurrent echocardiographic studies (within 24 hours of the IC recordings) as a means of comparison. During recording of the IC measurements, all patients were placed in the supine position. The IC tracings used were those that were determined to best represent the values obtained from approximately 15 minutes of continuous monitoring. Each aspect of the data was collected from the record by a single but different extractor. End systolic pressure (ESP) was estimated using the previously cited technique from automated brachial cuff pressures obtained simultaneous to the recording of the IC tracings.

In a qualitative validation of the accuracy of the method, the ESPVR was calculated from tracings recorded in a group healthy normal subjects (ages 19 - 30 years who volunteered in the calibration of the instrument) and compared retrospectively using the standard t test ($p < 0.05$) to those obtained from patients in compensated congestive heart failure (ejection fraction < 30% by echocardiogram). In the second part of the study, the noninvasive ESPVR measurements from a variety of patients with differing degrees of cardiac functioning were compared to the ejection fractions by concurrent echocardiograms (as determined by board certified cardiologists) using a linear regression analysis. Correlation coefficients are reported as r values with significance considered at the $p < 0.05$ level.

Results

Using the derived equation, the ESPVR for the normal group (6 volunteers, age 19-30 years) averaged 2.72 ± 0.71 . This was significantly different from the

1.04 +/- 0.45 found in 6 patients with known systolic dysfunction. In a comparative evaluation of the method, 64 patient records were examined and 18 were found to have concurrent echocardiograms. Three of these were excluded due to poor quality of the IC tracings. The ejection fractions obtained by echocardiography ranged from 20 to 65 % (mean = 48 %). Linear regression analysis revealed significant correlations ($r = 0.83$; $p < 0.01$) between the noninvasively estimated ESPVR and the concurrent echocardiographic ejection fractions (Figure 1).

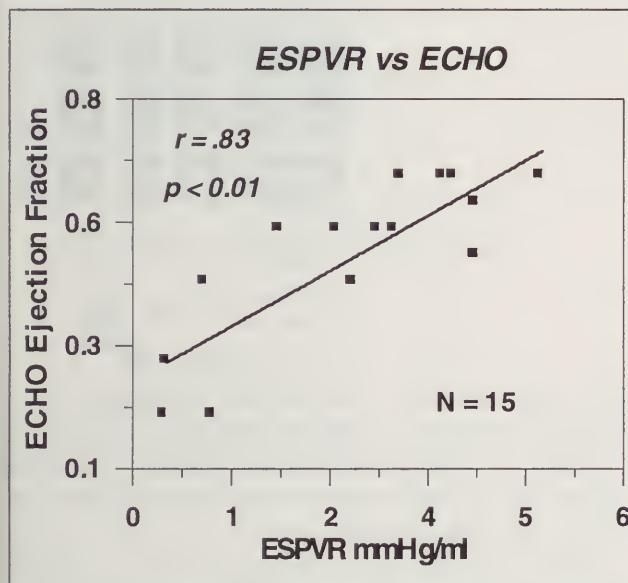


Fig 1.— Correlation of the noninvasively determined end-systolic pressure volume relationship (ESPVR) with the echocardiographic derived ejection fraction in fifteen patients with varying degrees of cardiac function.

Conclusions

The need to evaluate cardiac function is a common clinical problem. However, invasive measurements of myocardial contractility are not always practical in some clinical situations and the standard noninvasive techniques may be subject to varying preload, afterload and ventricular volume. The ESPVR was developed as an index of contractility by Suga and Sagawa and has been demonstrated to be unaffected by varying changes in hemodynamic conditions and may be the best overall measure of cardiac function.^{1,2} However, the use of ESPVR has been very limited because of difficulties in measuring end-systolic volume, which is usually only been accessible through very invasive procedures. In this study a noninvasive method for estimating the ESPVR that differentiates the myocardial contractile state was developed for use in the clinical setting. The method

relies heavily on the use of IC measurements to estimate the ejection fraction and stroke volume but has a sound theoretical foundation and provides a reasonable noninvasive estimate of this important parameter.

It is well known that there is a direct relationship between the PEP/LVET ratio and the left ventricular ejection fraction and a number of researchers have derived and validated formulas describing these relations.¹⁴ However, this noninvasive measure has not been widely used clinically due to the difficulties in recording and matching electrical and mechanical events of the left ventricle. IC provides an easily employed noninvasive tool for measuring both of these electromechanical cardiac intervals as well as effectively estimating the stroke volume.^{4,11,12,13,15}

There are several noted limitations to this study. The retrospective nature of the study limits the control of the environment in which the measures were taken. This could effect the consistency of the echocardiographic ejection fraction calculations and does not take into account the influence of different treatment regimens on the myocardial state of these patients. However, it would be expected that these factors would most likely result in a greater disparity between the IC and echo measures than we observed. Also, this varied cross-section of patients examined from a review of a large number of candidates probably represents a more realistic representation of the diversity of the intended emergent patients as opposed to a smaller group prospectively selected for routine echocardiography.

The limited number of patients that satisfied the selection criteria is of some concern. However, the number of patients examined is typical of similar studies currently present in the literature.^{4,13} While many more patients in the 64 records reviewed had echocardiograms from their past admissions, we thought the strict criteria of the 24 hour time limit between the IC and echo measures was necessary to limit the effects of time dependent factors on the observed contractility. The supposed gold standard of echocardiographic measurement of ejection fraction for comparison also has some significant inherent limitations. However, it was our intent to compare the IC measures of contractility to the best currently available noninvasive technology in common use. If the IC-based ESPVR measurements prove to be qualitatively consistent with the values obtained by echo, then this simple and inexpensive technology could potentially be used effectively for the continuous monitoring of cardiac function and without the limitations of the load conditions.

While this noninvasive, IC-based technique of

measuring ESPVR is validated qualitatively in the present study by a comparison to the current noninvasive gold standard of echocardiography, further investigation is needed to correlate the equation with invasive measurements.

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Address Reprints: Richard L. Summers, MD
Department of Emergency Medicine
University of Mississippi Medical Center
2500 North State Street
Jackson, Mississippi 39216
phone: 601-984-5586;
FAX: 601-984-5583;
email: rsummers@pol.net

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Utilization of Parenteral Nutrition in Patients Receiving Peripheral Blood Stem Cell Transplantation

Gordon S. Sacks, Pharm.D.

Srinivasa Ayinala, M.D.

Shirley S. Donelson, M.D.

Scott S. Malinowski, Pharm.D.

Anne F. Lipscomb, R.D.

Joe C. Files, M.D.

Makau Lee, M.D., Ph.D.

Abstract

A paucity of information is available on the use of parenteral nutrition (PN) in patients undergoing peripheral blood stem cell transplantation (PBSCT). To characterize the utilization of PN in patients undergoing PBSCT, we conducted a retrospective chart review study on adult patients receiving autologous and allogeneic PBSCT. Data collection included nutritional parameters such as indications for PN, days of PN administration, and PN-associated complications (i.e., metabolic, infectious, and mechanical). Outcome parameters assessed included length of hospitalization, days to engraftment, graft versus host disease (GVHD), and veno-occlusive disease (VOD). A total of twenty-one consecutive patients were evaluated with 12 receiving allogeneic PBSCT and 9 receiving autologous PBSCT. The allogeneic group received PN for a mean of 25 days compared to 21 days for the autologous group. The rate of metabolic abnormalities was significantly higher in the allogeneic group compared to the autologous group (1.02 abnormalities/PN days vs 0.61 abnormalities/PN day, $p < 0.05$), but mechanical and infectious complications were similar between the two groups. Length of hospitalization, days to engraftment, incidence of GVHD and VOD did not differ significantly between the two groups. However, mortality prior to discharge was significantly higher in the allogeneic vs autologous group (58% vs 0%, $p < 0.05$). We conclude that allogeneic PBSCT patients appear to be at a greater risk for metabolic complications while receiv-

ing PN as compared to autologous PBSCT patients. As nausea and vomiting are two primary reasons for initiation of PN in this patient population, further studies of aggressive antiemetic therapy may prove to decrease the need for PN in PBSCT patients.

Key words: Parenteral Nutrition
Peripheral Blood Stem Cell Transplantation
Bone Marrow Transplantation

Introduction

Malnutrition and metabolic alterations are frequent complications in patients undergoing bone marrow transplantation (BMT). Severe gastrointestinal side effects such as anorexia, nausea, vomiting, mucositis, and diarrhea often occur secondary to preparative cytoreductive chemotherapy, irradiation, or graft versus host disease (GVHD). These side effects often preclude adequate oral intake in these patients. Appropriate nutritional intake is an essential component in minimizing the risks of morbidity and mortality associated with malnutrition in BMT patients. As a result, parenteral nutrition (PN) has become the mainstay of nutrition support in BMT. The use of PN for all BMT patients is controversial, as some studies have demonstrated successful outcomes with enteral nutrition.^{1,2} However, other investigators have shown that the majority of BMT patients ultimately require PN as a

result of documented nutritional depletion when enteral nutrition was attempted.³

Clinical trials throughout the last decade have shown that blood-derived pluripotent hematopoietic progenitor cells can reliably result in rapid and complete hematopoietic recovery in patients receiving high-dose chemotherapy and irradiation.⁴ As a result, peripheral blood stem cells are currently replacing bone marrow as the optimal source of stem cells for reconstitution following BMT conditioning regimens. A paucity of information is available on the use of PN in patients undergoing peripheral blood stem cell transplantation (PBSCT). The purpose of this study was to characterize the utilization of PN in patients undergoing autologous and allogeneic PBSCT.

Materials and Methods

A retrospective chart review was conducted on adult patients admitted to the Hematology Service at the University of Mississippi Medical Center, Jackson, Mississippi between September 1995 and December 1996. Consecutive adult patients undergoing autologous and allogeneic PBSCT were included in the analysis. Data collection included nutritional parameters such as indications for PN, days of PN, and PN-associated complications (i.e., metabolic, infectious, and mechanical). To evaluate for the influence of PN on outcome, data was collected to evaluate length of hospitalization, days to engraftment, GVHD, veno-occlusive disease (VOD) and

mortality. Unpaired *t*-tests were used to compare days of PN, days to engraftment, and length of hospitalization. The rate of PN-associated complications (i.e., metabolic, infectious, and mechanical), GVHD, VOD, and mortality were analyzed with Chi Square analysis or Fischer Exact Test when appropriate. A *p* < 0.05 was considered statistically significant.

Results

A total of 21 patients were analyzed. Twelve patients received allogeneic PBSCT and nine patients received autologous PBSCT. Common admitting diagnoses among allogeneic transplant patients included acute myeloid leukemia, chronic myeloid leukemia, chronic lymphocytic leukemia, and aplastic anemia. The most common hematological diseases occurring in the autologous transplant patients included acute myeloid leukemia and non-Hodgkin's lymphoma. Demographic data are presented in Table 1.

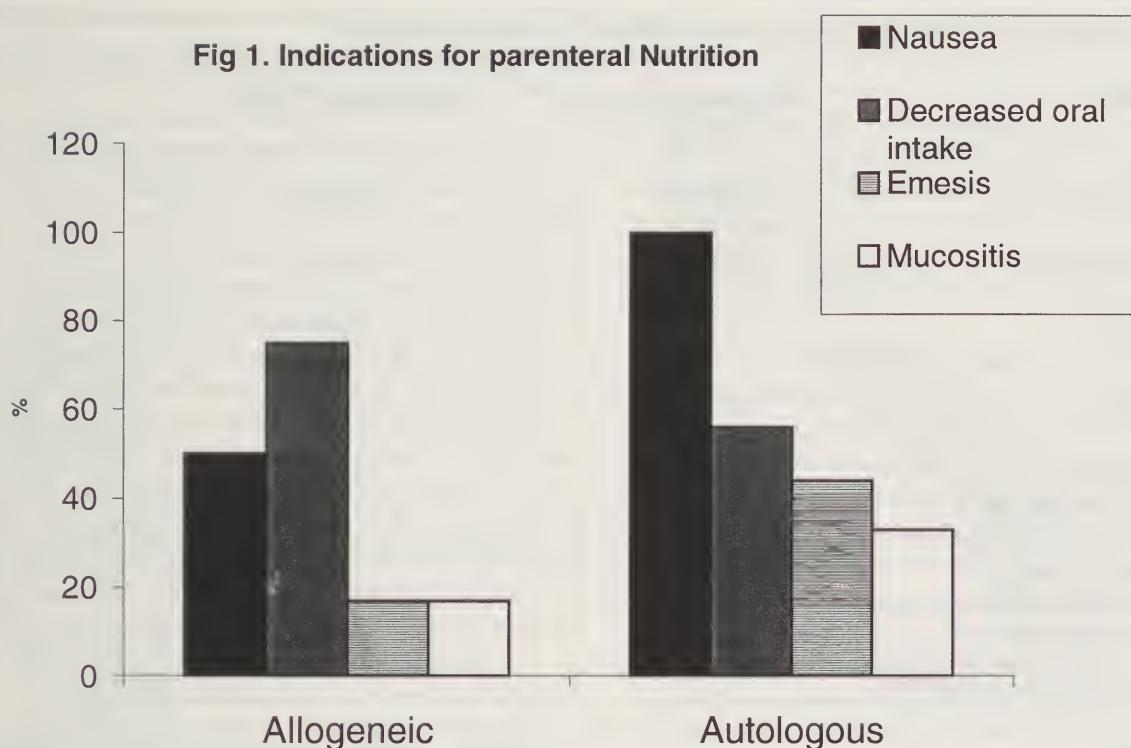
Nausea, vomiting, and decreased oral intake were the most common indications for initiation of PN (Figure 1). Allogeneic PBSCT patients received PN for a mean of 25 days compared to 21 days for the autologous group (*p* > 0.05). During PN administration, patients were evaluated for the presence of metabolic complications including alterations in potassium (< 3.5 mmol/L and > 5.1 mmol/L), magnesium (< 1.3 mEq/L and > 2.0 mEq/L), phosphorus (< 2.5 mg/dL and > 4.5 mg/dL), and glucose (> 200 mg/dL). The allogeneic group experienced signifi-

Table 1— Demographic data comparing the indications for allogeneic versus autologous PBSCT

Parameter	Allogeneic (n=12)	Autologous (n=9)
Age (years)	38 ± 11 (23-51) ^a	43 ± 11 (22-56)
Gender (M/F)	7/5	5/4
Diagnosis		
Acute myeloid leukemia	3	2
Chronic myeloid leukemia	3	0
Aplastic anemia	2	0
Non-Hodgkin's lymphoma	1	4
Chronic lymphocytic leukemia	2	
Breast cancer	0	1
Acute lymphoblastic leukemia	1	0
Testicular cancer	0	1
Multiple myeloma	0	1

a- Mean ± SD (range)

Fig 1. Indications for parenteral Nutrition



cantly more days with alterations in serum magnesium ($X^2=35.9$, $p<0.05$) and phosphorus ($X^2=4.7$, $p=0.03$) as compared to the autologous group. When all metabolic complications were combined, the allogeneic group experienced more abnormalities per PN day vs the autologous group (1.02 abnormalities/PN day vs 0.61 abnormalities/ PN day, $X^2=135.9$, $p<0.05$). Results of all metabolic complications are listed in Table 2. Metabolic complications occurred between day 3 to day 34 post transplantation in allogeneic patients and between day 13 to day 28 post transplantation in the autologous group.

Mechanical complications and infectious complications did not differ between groups.

Assessment of outcome parameters for both groups was conducted. No significant differences in hospital length of stay, days to engraftment, incidence of GVHD, and VOD were noted between the groups. Mortality prior to hospital discharge was significantly higher for patients undergoing allogeneic vs autologous PBSCT (58% vs 0%, Fischer exact, $p=0.007$). Results of outcome parameters are shown in Table 3.

Table 2— Metabolic complications in allogeneic versus autologous group

	Allogeneic	Autologous
Potassium	0.17 ^a	0.18
Magnesium	0.2 ^b	0.05
Phosphorus	0.32 ^c	0.16
Glucose	0.2	0.19
Total	1.01 ^d	0.61

a- Number of episodes of metabolic abnormalities/day of PN

b- $P<0.05$ versus autologous group

c- $P<0.003$ versus autologous group

d- $P<0.05$ versus autologous group

Table 3— Final outcome in allogenic versus autologous PBSCT on parenteral nutrition

Parameter	Allogeneic (n=12)	Autologous (n=9)
LOS (days)	34 ± 11 ^a	29 ± 3
Days to engraft	13 ± 10	14± 3
GVHD (%)	0.2 ± 0.4	N/A
VOD (%)	0.5 ± 0.7	0
Mortality (%) (Prior to Discharge)	58 ^b	0

a- Mean ± SD (range)

b- p<0.05 versus autologous group

LOS = Length of stay

GVHD = Graft versus host disease

VOD = Venoocclusive diseases

Discussion

Peripheral blood stem cells are currently replacing bone marrow as the optimal source of stem cells for reconstitution after irradiation and chemotherapy. As an alternative to surgically harvested bone marrow, PBSCT is becoming more popular due to less invasiveness and decreased risk to the patient. Recent evidence further suggests that PBSCT is more cost effective and can result in a more rapid recovery period for patients as compared to conventional BMT.⁶ Despite the advantages of PBSCT, alterations in nutritional status may often result due to underlying hematological diseases and BMT conditioning regimens. Nausea and vomiting are frequently observed after chemotherapy, most commonly in the first two weeks post transplantation. Nausea, vomiting, and decreased oral intake were the most common gastrointestinal side effects occurring in our patients that precluded adequate oral intake and required initiation of PN. A variety of gastrointestinal complications have been reported to impair oral intake during BMT. Oropharyngeal mucositis commonly results from pretransplant regimens and may persist for 3 to 4 weeks post transplantation.⁶ Similarly, esophagitis often occurs as a result of chemotherapy, acid reflux, or GVHD.⁷ Alterations in taste perception or diarrhea have also been noted to last for weeks after transplantation. All of these adverse consequences of chemotherapy and transplantation contribute to an alteration in nutritional status and the need for PN as a standard supportive care.

PN is a highly complex therapeutic intervention that can be associated with infectious, mechanical, and metabolic complications. Catheter-related bacteremias and fungemias are important infectious risks associated with PN administration. Increases in patient morbidity and hospital expenditures have been associated with catheter-related infections.⁸ Preventive measures such as strict aseptic technique during line insertion and limiting catheter manipulation can reduce the incidence of infectious complications observed with PN. In our study, the incidence of catheter-related infection was similar in both groups and no patient deaths were attributable to catheter infection. Mechanical complications associated with PN include occlusion of centrally-placed catheters due to the development of fibrin sheaths, drug-mineral precipitates, or intravenous lipid deposition. Removal of catheters was not required for any of these reasons during the evaluation period.

Acute problems with PN are primarily metabolic complications, which include electrolyte imbalances. Disorders in electrolyte homeostasis identified in our patients included phosphorus, magnesium, potassium, and glucose. Phosphorus abnormalities, both hypo- and hyperphosphatemia, occurred on 127 of 482 days (26.3%) of PN for all patients. Interestingly, the proportion of phosphorus abnormalities was significantly higher in the allogeneic vs autologous patients (0.32 vs 0.16 abnormalities/days of PN, p < 0.05). Low serum phosphorus concentrations (< 2.5 mg/dL) comprised the majority of

days that phosphorus concentrations were abnormal (93 of 482 PN days or 19%) for both patient groups. Although the incidence of hypophosphatemia in the general hospital population has been reported to be 0.5% to 3%, we have previously reported that patients receiving specialized nutrition support demonstrate a substantially higher rate of approximately 30%.⁹ Mechanisms responsible for this alteration include an increased uptake of phosphorus for phosphorylated intermediates of glycolysis, increased requirements for tissue anabolism in the undernourished patient, and an intracellular shift of phosphorus in response to hyperinsulinemia from large doses of glucose administration. Case reports of hypophosphatemia occurring in bone marrow transplant patients have been reported by other investigators.^{10,11} One proposed mechanism for hypophosphatemia is an increased uptake of phosphorus due to hematopoietic recovery following transplantation. However, this would not explain the difference in low phosphorus concentrations between autologous and allogeneic patients in our study.

Magnesium abnormalities were highly prevalent in our cohort of patients. Alterations in serum magnesium concentrations occurred on 95 of 482 PN days (19.7%) for all patients. Similar to phosphorus, the majority of these days were the result of low serum magnesium concentrations (< 1.2 mEq/L). Hypomagnesemia occurred on 87 of 482 PN days (18%) for autologous and allogeneic patients. In large urban city hospitals, the prevalence of hypomagnesemia has been reported to be as low as 10% in the general population but as high as 65% in medical intensive care patients.¹² Although not evaluated in bone marrow transplantation, cyclosporin-induced hypomagnesemia has been studied in renal transplant patients. An intracellular shift¹³ and urinary wasting of magnesium¹⁴ have been noted as etiologies for magnesium deficiency observed in patients receiving cyclosporin. This medication-induced electrolyte disorder may account for the difference in days of hypomagnesemia experienced by allogeneic vs autologous patients (77 of 84 days vs 10 of 11 days, $p < 0.05$).

The intimate relationship between magnesium and potassium homeostasis is well recognized. Because magnesium plays a primary role in the regulation of membrane adenosine triphosphatase activity, hypomagnesemia can predispose patients to hypokalemia.¹² Days of hypokalemia (<3.5 mmol/L) experienced by all patients (81 of 482 PN days or 16.8%) is similar to reports of hypokalemia noted in other hospitalized patient populations.¹⁵ Numerous medications may cause abnormal losses of potassium, most notably diuretic therapy. However, our patients received pre-transplant regimens of cisplatin

and post-transplant regimens of amphotericin B or extended penicillin derivatives that have been shown to promote renal potassium elimination. Although less common, hyperkalemia (> 5.1 mmol/L) occurred in both patient groups. Reports of elevated serum concentrations have been previously observed in allogeneic bone marrow transplant patients receiving cyclosporin.¹⁶ Although the etiology remains elusive, investigators believe the mechanism is associated with an aldosterone-resistant state.

Glucose homeostasis is particularly important in BMT patients due to observations of immunosuppression and increased infection associated with episodes of hyperglycemia. Abnormalities in phagocytosis, chemotaxis, and complement function have occurred in patients with uncontrolled glucose concentrations (> 200 mg/dL).¹⁷ Patients receiving PN and experiencing hyperglycemia have also been found to exhibit a higher frequency of infectious complications. Elevated serum glucose concentrations occurred on 107 of 482 PN days (22%). Although our patients were inherently at risk for infection due to neutropenia, hyperglycemia may have further contributed to alterations in their immune response.

Alterations in liver function may accompany the administration of PN. These complications are primarily due to excessive glucose administration or prolonged *nil per os* (NPO) status.¹⁸ Although unrelated to the administration of PN, veno-occlusive disease (VOD) can develop following bone marrow transplantation. This disorder is associated with hepatomegaly, jaundice, ascites, and unexplained weight gain. Increased age and evidence of pretransplant liver abnormalities appear to be predisposing factors.¹⁹ Moreover acute graft versus host disease (GVHD) can be a complication after allogeneic BMT that may also manifest as hepatic injury.²⁰ In the present study, the incidence of VOD or GVHD was not significantly different between allogeneic and autologous patients receiving PN.

We conclude that allogeneic PBSCT patients are at greater risk for metabolic complications during PN administration as compared to autologous PBSCT patients. Because two primary indications for initiation of PN were nausea and vomiting, use of aggressive antiemetic therapy could minimize the utilization of PN. By decreasing the need for PN, adverse consequences such as metabolic complications and the expense associated with this intervention could be eliminated.

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Contributing Authors:

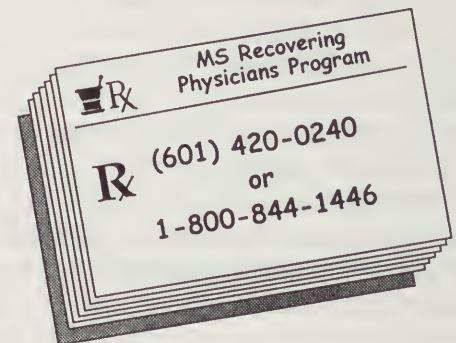
Gordon S. Sacks, Pharm.D.
Srinivasa Ayinala, M.D.
Shirley S. Donelson, M.D.
Scott S. Malinowski, Pharm.D.
Anne F. Lipscomb, R.D.
Joe C. Files, M.D.
Makau Lee, M.D., Ph.D.

University of Mississippi Medical Center,
Jackson, Mississippi

Corresponding Author:

Makau Lee, M.D. Ph. D.
Division of Digestive Diseases
University of Mississippi Medical Center
2500 North State Street; Jackson, MS 39216
Phone: 601-984-4549; Fax: 601-984-4548

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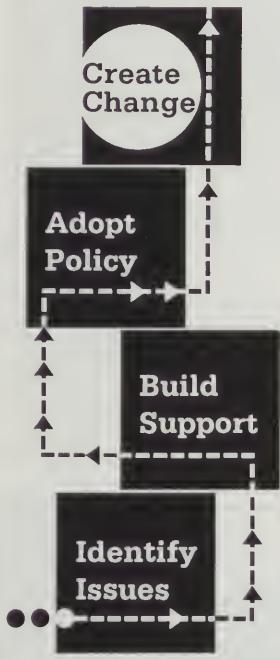
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An Interview With 2000-01 MSMA President Candace E. Keller, M.D., M.P.H.

Let's start at the beginning. Where did you grow up? Tell me about your upbringing.

I was born and reared in Laurel, MS., the firstborn to my parents Bill and Ann Keller. I have two brothers, John and Steve; my sister-in-law, Lynn; and my niece, Leslie Ann and nephew, John Michael.

What schools did you attend?

I was a student of the Laurel public school system from first through twelfth grade and graduated in the top ten of my class from R.H. Watkins High School in 1970. I have always loved learning which was instilled in me from the beginning by my first grade teacher, Mrs. Walter Booher. I developed a particular interest in math and science. In the summer of 1969, I attended the Scieneers Institute at Mississippi State University. Although not nearly as smart as most of the other kids there that summer, it was a positive experience and a determining factor in my ultimate decision to pursue a medical career.

I chose to attend college at the University of New Orleans where I had a double major in pre-med and medical technology. My father had advised me to get a bachelors degree with which I could obtain a job if I needed one and the B.S. in medical technology allowed me the means to work summers and part time during medical school. I entered University of Mississippi School of Medicine in the fall following my college graduation.



Young Candace loved learning, a trait which was instilled in her at an early age by her first grade teacher, Mrs. Walter Booher. She developed a particular interest in math and science.



Candace E. Keller as a child.



Miss Keller at senior graduation festivities at R. H. Watkins High School in Laurel, Mississippi.

At what point did you realize you wanted to go to medical school?

My earliest recollection is from the fifth grade. I had a family member that year who became seriously ill. Our teacher one day asked us to draw a picture about what we wanted to be when we grew up. I remember thinking that if I just knew what to do, I would help my sick loved one get well and I drew a picture of a patient on a stretcher with a doctor standing nearby.

My interests in science were fostered by dedicated teachers in junior high and high school. My parents never channelled me specifically in any one direction, but to their credit, they always encouraged me that I could do and be anything I chose to be. Their unwavering support is largely responsible for whatever success I have achieved.





Keller family, Christmas 1999. Seated: Dr. Keller's mother, Ann Keller; her niece, Leslie Ann and nephew, John Michael, and her father, Bill. Standing: Her brother, John; his wife, Lynn; Candace and her other brother Steve.

I considered my education in blocks — college, medical school, residency. Toward the conclusion of each segment, I tried to evaluate whether to proceed to the next and one just led to another.

What are the best memories you have of life as a medical student?

To be honest, the medical school years now are pretty much a blur. It did not come as easily for me as my previous studies had, and I only recall being buried in books and clinical duties during that time. The best part is that I made some lifelong friends, particularly among the women in my class.

Graduation Day, June 1993, Harvard University. Candace E. Keller, M.D. added a Masters in Public Health to her education credentials.

Were there some unfavorable things you recall as well?

The worst part is that I don't think I had as much fun as some of my classmates seem to have had.

What was your residency like?

I began my residency in general surgery at the University of Mississippi Medical School of Medicine (UMC) in Jackson, but I subsequently decided to switch to anesthesiology. I completed my anesthesia residency at the University of Texas Medical Branch in Galveston with Dr. James Arens. I am very fortunate and blessed to have been a resident in the program there. I received excellent training and again made many great friends. We worked long hours, but we also learned to have fun along the way.

After residency, I came back to Mississippi and practiced in Laurel for about a year prior to moving to Hattiesburg. My practice has been primarily in the private practice setting. I have also worked as a clinical coordinator at Information and Quality Healthcare (formerly Mississippi Foundation for Medical Care) in the Healthcare Quality Improvement Program since 1994.



How did the desire to obtain your Masters in Public Health (M.P.H.) come about? What were your years at Harvard like?

As a result of my involvement in organized medicine as well as general observation of the changes occurring in medical practice, in the early 90's I began to investigate various options to continue my educational pursuits with the goal of enhancing my knowledge and increasing my career opportunities for the future. I looked into various types of programs ranging from business to health administration. At an A.M.A. meeting, a friend suggested I check into the M.P.H. program at Harvard, and so I did. Thankfully, he also warned me not to be intimidated by the essay requirement on the application. Otherwise, I probably would not have even sent it. Much to my amazement, I was accepted!

So in the fall of 1992, after eight years in practice, I took a year off and journeyed to Boston for what turned out to be one of the greatest experiences of my life. The MPH program at the Harvard School of Public Health is designed for and composed of mostly physicians. Approximately one half of my class were doctors from other countries around the world. We often hear our healthcare system referred to as the best in the world; but, having had an opportunity to listen to stories about other places firsthand from the doctors who live and work there, I know it's true.

I chose the Health Policy and Management track as my MPH emphasis. My faculty adviser, Dr. Heather Palmer, is involved in quality improvement research and I had an opportunity to study with some of the real giants in the field including Dr. Don Berwick. It was a truly great year.

What's do you like most about being an anesthesiologist?

I like being able to concentrate on treating one patient at a time. I enjoy the interaction with patients as well as working in the operating room.

You've been extremely involved in organized medicine. Could you highlight some of the challenges you've faced in your various appointments?

I think the biggest challenge has been finding the time and juggling all the various schedules. There are many opportunities for involvement for anyone who is willing to show up and participate. The hard part is often learning how to say no.

Although there were not avenues for me to get involved in organized medicine as a medical student and resident as there are for them today, I had very strong role models in Dr. Carl Evers, who was extremely active in the AMA, and Dr. Arens, who was active in the ASA. I believe their influence, as well as a desire to give back something to the profession, have been two of the main motivating factors in my involvement.

Tell me about your offices in the Mississippi Society of Anesthesiologists and also the American Society of Anesthesiologists?

I got involved in the MS Society of Anesthesiologists as well as MSMA soon after my residency in 1984. I have served as Secretary, President-elect, and President. I was the Alternate Director from Mississippi to the ASA Board of Directors until this past October when I was elected to Vice-Speaker of the ASA House of Delegates.



Left to right: AMA Alternate Delegates Alton B. Cobb, M.D.; Candace E. Keller, M.D.; and George E. McGee, M.D. confer with AMA Delegate Carl G. Evers, M.D. at an AMA meeting in Chicago. Dr. Keller began attending AMA meetings through the Young Physicians Section until 1992 when she was first elected Alternate Delegate from Mississippi to the AMA's national House of Delegates.

Tell me about your leadership activities with the Mississippi State Medical Association (MSMA) and the American Medical Association (AMA)?

My MSMA and AMA activities have actually paralleled one another. I initially became a delegate to the MSMA House of Delegates representing the MS. Society of Anesthesiologists. Later on in 1988, Dr. George McGee, who was one of the original members of the AMA Young Physicians Section, mentioned to me during a case one day that the ASA had not yet sent anyone to represent the ASA in the Young Physicians Section (YPS). I wasn't looking for an appointment, but somehow in the process of making a call to advise the ASA of this need, I ended up with the job! So I began attending AMA meetings through the YPS until 1992 when I was elected first elected as an Alternate Delegate from Mississippi to the "big" House of Delegates.

I was privileged to serve on the AMA's Women in Medicine Advisory Panel for a number of years and as Vice Chair in my final term. More recently, I have been serving as a member of the American Medical Political Action Committee (AMPAC) Board of Directors.

All of my organized medicine activities have not only enabled me to learn, grow, and hopefully to make some meaningful contribution, but also have afforded me the opportunity to meet and listen to physicians from many different specialties, practice settings, and geographic locations. I have made many wonderful friends over the years.

How do you make time for a personal life? What do you do in your leisure time?

Well, it is challenging, but we all learn to prioritize and make time for family and friends. I suppose organized medicine has become my main "hobby" for the past several years, but I also enjoy leisure travel, skiing, and reading. There isn't much leisure time these days, but that will improve in future years.



"Arens-Trained Anesthesiologists" skiing in Utah.

CANDACE E. KELLER, M.D., M.P.H.

EDUCATION

University of New Orleans, New Orleans, LA
Bachelor of Science in Medical Technology 1974

University of Mississippi School of Medicine, Jackson, MS
Doctor of Medicine 1978

Harvard School of Public Health, Boston, MA
Master of Public Health 1993

University of Mississippi Medical Center, Jackson, MS
Internship and General Surgery 1978-1981

University of Texas Medical Branch, Galveston, TX
Anesthesiology Residency 1982-1984

PROFESSIONAL ASSOCIATIONS:

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Vice Speaker, House of Delegates 2000
Alternate Director, Mississippi 1991-present
Task Force on Structure and Governance 1999
Task Force on Preoperative Fasting Advisory 1998
Committee on Physician Resources 1997, 1998-present
Committee on Membership 1997, 1998-present
Quality Improvement Committee 1995, 1999-present
Committee on Professional Diversity 1994, 1995
Ad Hoc Committee on Anesthesia
 in Underserved America 1994
Committee on Anesthesia Care Team 1990-1993
Ad-Hoc Committee on
 Medical Direction Payments 1991-1993
Young Physicians Liaison
 Committee to AMA, Chair 1989-1991
Delegate, House of Delegates 1989-1991
 Non-voting member 1991 -present
Reference Committee 1989, 1992, 1994, 1998, 1999
 Chair 1997

MISSISSIPPI SOCIETY OF ANESTHESIOLOGISTS

President 1995
President-elect 1994
Secretary 1986-1989
Executive Committee 1986-present

AMERICAN MEDICAL ASSOCIATION

American Medical Political
 Action Committee Board 1996-present
AMA House of Delegates
 Delegate, Mississippi 1999-present
 Alternate Delegate, Mississippi 1992-1998
 Reference Committee 1996 *continued...*

...continued

AMERICAN MEDICAL ASSOCIATION

Women in Medicine Advisory Panel	1992-1997
CoChair	1995,1996,1997
AMA Representative to the Society for Advancement of Women's Health Research, Medical Health Advisory Board	1993-1997
Delegate, Young Physicians Section	1989-1991

MISSISSIPPI STATE MEDICAL ASSOCIATION

President	2000 (May 21)
President-Elect	1998
Secretary-Treasurer	1994-1998
Board of Trustees	1994-present
Delegate, House of Delegates	1989-present
Reference Committee	1990, 1993, Chair 1994
Mississippi Medical Political Action Committee	1995-present
Young Physicians Section	1988-1991, Secretary 1991
Governing Council	

PROFESSIONAL EXPERIENCE:

PRIVATE PRACTICE

Wesley Medical Center	Hattiesburg, MS
Anesthesiologist	1984-1992, 1993-present
Quality Assurance Committee	1986
Surgery Services Committee	1989
Surgical Quality Improvement Committee	1994,1995
Utilization Review Committee	1995
Forrest General Hospital	Hattiesburg, MS
Anesthesiologist	1984-1992, 1993-present
Infection Control Committee	1985,1996
Quality Assurance Committee	1987
Medical Records Committee	1989,1990

ADDITIONAL:

University of Mississippi Medical Center	Jackson, MS
Department of Anesthesiology	
Assistant Clinical Professor	1999-present
Information and Quality Healthcare Clinical Coordinator	Jackson, MS
	1994-present
Harvard Community Health Plan Research Consultant	Boston, MA
	1993

CERTIFICATIONS:

Diplomate, American Board of Anesthesiology 1985

How does it feel to be the first female physician elected to the office of MSMA President in the 144-year history of its existence?

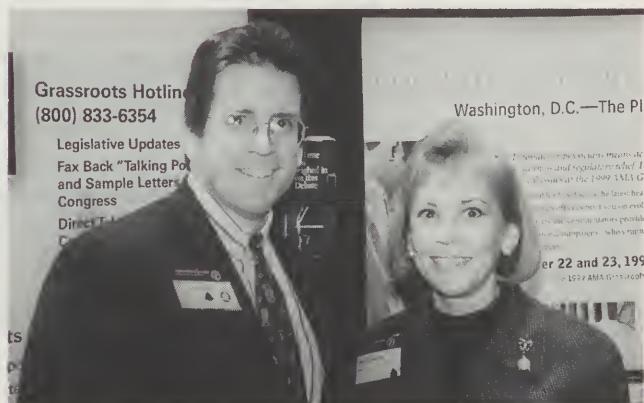
I am very honored to have been elected by my peers to be the MSMA President. It is a tremendous honor and responsibility for anyone, regardless of gender, race, or ethnicity, to assume this office. While I may be the first woman to serve the MSMA in this capacity, I certainly will not be the last. I hope that my presidency will be an inspiration to other women who follow.

What do you envision being your major challenges as MSMA President?

I think that all physicians feel overwhelmed on a variety of fronts and thus we are all challenged to maintain our focus on providing patient care of the highest quality and maintaining our unity as physicians first, specialists second. Reminding our troops to keep the faith and stay on the battlefield will be part of my mission.

Is there anything else you would like for members to know about that I have not asked you?

I look forward to leading MSMA in the coming year. I will continue to emphasize the importance of physician participation in the political process through membership in MMPAC, our political action committee, as well as personal interaction with both our state and Congressional legislators. The time for apathy is long past and every MSMA physician and Alliance member must get involved. I plan to highlight some opportunities to improve the health of Mississippi citizens in which physicians can play a pivotal role. And last, but perhaps most importantly of all, I will promote the critical need to preserve our unity as we face the future.



Dr. Bob Hertzka, AMPAC Board member from San Diego, California and Dr. Candace Keller in front of an AMPAC exhibit at a 1999 AMA meeting in Chicago.



W. Briggs Hopson, Jr., M.D. The President's Page

Do You Serve?

Many years ago a great aunt of mine told me that the two noblest professions one could pursue were the ministry and medicine. Different in many respects but noble because they both were professions of service to mankind. Professions where those sick of body, sick of mind, or sick of heart were served. Professions where family, friends, and finance were second in line to those who needed care, professions where reward came from seeing the unhealthy return to health or comforting the family of those dying, professions that had no time clock and no time limits.

In recent travels around the state I have talked about battles we have almost lost in the legislature this year—battles with nurse practitioners, optometrists, and all who would take a bite out of medical practice. I have asked those in the audience to tell me why and what we should do. Over half a dozen physicians have stopped me and said the same thing. We as physicians have forgotten how to serve. We cut our pagers off at 5 o'clock. We ignore patients' and family calls. We tell our nurses to take care of that problem. We tell our patients to go to the emergency room. We hurry through rounds not stopping to discuss illness with patients or family. We have a "better than thou" attitude. We have forgotten that it is more important to listen for 15 minutes than to see 80 patients a day. We seem to have forgotten that ours is a profession of service and not a business.

Fifty years ago physicians were leaders in the community, leaders in the legislature. They were revered more than any other profession—always givers, not takers. In this my final president's page, I ask you to look in the mirror that I mentioned in my acceptance speech and ask yourself, "Have I truly served my fellowman, putting him before all else?" I close with two quotations, the first from Abigail Adams, the second from Albert Einstein. (1) "If we do not lay out ourselves in the service of mankind, who should we serve?" (2) "Only a life lived for others is a life worth living."

Thank you for allowing me to serve you.

A handwritten signature in black ink, appearing to read "Briggs". The signature is fluid and cursive, with a large, stylized 'B' at the beginning.

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XLI, NUMBER 5
MAY 2000

MAY YOU LIVE IN INTERESTING TIMES?

Yeah, that phrase again. I first heard it during a discussion of the MSMA's HMO project in the 1980's and have sworn I'd never use it in an essay. I've heard it a number of times since, always wondering what sort of dull life the speaker yearned for, as if mowing the grass represented the most perfect passage of time.

The only reason the phrase seems a curse at all is in the enunciation, the faintly sinister, mysterious tone of voice reserved for that true Chinese curse "May your bowels be seized." Yes, these are interesting times. *The New England Journal of Medicine* recently published a study of a new drug to treat rheumatoid arthritis. The drug was not simply another form of Motrin, tortured into a slightly different shape. This stuff, etanercept, is made in a test tube, a designer molecule consisting of a receptor for the cytokine tumor-necrosis factor linked to an immunoglobulin G. When tumor necrosis factor is soaked up by the etanercept, the inflammatory problems related to TNF—i.e. rheumatoid arthritis—are substantially, and safely, relieved.

This is what's going on in these biotech labs, the stocks of which soar (and crash, though I'll save that for a more cynical editorial.) Now, this day, is a marvelous time to be practicing medicine. With the conclusion of the human genome project this year the resulting drugs will revolutionize medicine in a way only comparable to the development of antisepsis, four years after the great victory at Chickamauga.

In the political and social realm we face grave threats. Businessmen try to control our actions for their own profit. Many patients have fixated on these preposterous medieval herbs. For some inexplicable reason someone has chosen us to defend medical professionalism against these onslaughts just as the British were called on in 1941 to save democracy. What one comes to realize after careful contemplation is this time, this day, is it. "It" was not twenty years ago before managed care, or thirty-five years ago before Medicare. This is it.

Yes, we live in interesting times. No, on second thought, we live in fascinating times.

—Leslie E. England, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

Medical Assurance Company of Mississippi



Liability and your Practice

MaryAnn Wee, RN, BSN

Q. We are adding hospitalists to our medical clinic to care for our patients who are hospitalized. Since this is a new specialty in our clinic, what are the risks for both the hospitalists and our primary care physicians who use them?

A. Hospitalists who care for and coordinate the hospital care of patients for the primary care physician represent an emerging specialty. Areas of potential risk for the primary care physician could include allegations of abandonment of the patient, negligent referral, or failure to follow up on the patient's condition. The hospitalist faces liability risk in the areas of practicing beyond specialty/scope and failing to communicate with the referring physician or with the patient.

The key to successfully implementing a hospitalist program is communication/education and well established risk management systems. Inform the new clinic patients that their care may include hospitalists if they are hospitalized. If the need arises, remind the patient and his family of this when the patient is admitted. A brief information sheet outlining the concept of hospitalists and giving the names of the hospitalists who will be caring for the patient would be helpful. If the patient objects, then the primary care physician should admit and follow the patient during hospitalization. A visit from the primary care physician during hospitalization can serve to maintain the continuum of care. Mutually agreed upon policy should be developed to assure the discharged patient will receive follow-up by the primary care physician. Appointment for follow-up should be given to the patient prior to discharge; discharge summaries and pertinent records should be provided to the primary care office in a timely manner. Any test results obtained after discharge should be forwarded to the primary care office after they have been reviewed and evaluated by the hospitalist. If there is a significant abnormality, this should be communicated verbally to the primary care physician, with written follow-up. Policy should be established outlining who will be responsible for contacting the patient.

Since this is a new specialty, the credentialing process in the hospital should be complete. The exact scope of the hospitalist's duties should be defined, and all physicians using the hospitalists should be educated on their role. Prior to initiating the use of hospitalists in the hospital, an educational campaign should be undertaken for medical staff and hospital staff on the role of the hospitalist.

MaryAnn Wee serves as Senior Risk Management Consultant for Medical Assurance Company of Mississippi. MACM will feature articles on risk management, legislation and current liability issues facing Mississippi physicians today.

132ND ANNUAL SESSION & MEDICAL AFFAIRS FORUM



May 18-21, 2000

**Beau Rivage Resort
on the Mississippi Gulf Coast**





GENERAL INFORMATION

REFERENCE COMMITTEES

All MSMA members may participate in reference committee hearings. Members are encouraged to participate in references committee meetings as policies of the Association are established. All meetings will be held consecutively.

The schedule is as follows:

2:00 PM	Reference Committee on Constitution and Bylaws
2:30 PM	Reference Committee A
4:00 PM	Reference Committee B

CME CREDIT

The MSMA Council on Scientific Assembly is accredited by the MSMA Council on Medical Education to sponsor intrastate continuing medical education for physicians. CME Credit hours will be listed in the official program of the 132nd Annual Session. Be sure to save the program's back panel.

MACM GOLF TOURNAMENT

Medical Assurance Company of Mississippi will reinstate the tradition of sponsoring its annual golf tournament. The tournament will be held at Great Southern Golf Club, 1:00 PM., Thursday, May 18. Prizes will be awarded.

Members and their spouses are invited to all social events which are all complimentary except the **President's Inaugural Celebration** (Black Tie Optional), to which tickets may be purchased at a nominal charge to offset costs.

THE PRESIDENT'S RECEPTION

The annual **President's Reception** will be held Friday evening, May 19, on the Beau Rivage Special Events Deck overlooking the Gulf, from 6:30 P.M. to 8:30 P.M. Enjoy the "Rhythm of The Islands" with steel drum music performed by David Wahl. Since their inception in 1987, *The Tropical Steel Band* has been one of the most truly innovative and entertaining musical groups along the Gulf Coast. Following the reception, guests are invited to an ice cream social sponsored by Southern Medical Association.

MSMA PRESIDENT'S INAUGURAL CELEBRATION AND MSMA ALLIANCE SILENT AUCTION

With the beginning of new Millennium, MSMA will initiate a new practice of conducting the President-elect's Inauguration on Saturday evening, rather than during the closing session of the House of Delegates on Sunday morning. This very special dinner/dance event, which will be black tie optional, will include the inauguration of Dr. Candace Keller as MSMA's 133rd President, special recognition of MSMA's component society Presidents, the MSMA Alliance's annual Silent Auction to benefit the AMA Foundation, and entertainment by several former Miss Americas. All MSMA and MSMA Alliance members should have received an invitation and information about purchasing tickets for this memorable and fun evening.

COMPONENT SOCIETY CAUCUSES

If your component society plans to hold a caucus you need to reserve a location a.s.a.p. Planning for meeting rooms has already occurred and there is limited space for small groups.

MSMA 132nd Annual Session and Scientific Assembly

May 18-21, 2000

Beau Rivage • Biloxi, MS • 1-888-567-6667

SCHEDEULE

THURSDAY, MAY 18

11:00 a.m.	Executive Planning Group Benefit Lunch Meeting
1:00 p.m.	Registration
	MACM Golf Tournament
2:00 p.m.	Exhibitor set-up
4:00 p.m.	Board of Trustees Meeting

FRIDAY, MAY 19

7:30 a.m.	Continental Breakfast with Exhibitors (Sponsored by Horne CPA Group)
	Component Society Presidents' Meeting
	MS Eye, Ear, Nose & Throat Association Breakfast
8:00 a.m.	Registration
	Reference Committee Orientation
9:00 a.m.	House of Delegates
11:00 a.m.	Lunch with Exhibitors
11:30 p.m.	Alliance Pre-Convention Lunch Meeting
	Mississippi Association of Public Health Physicians Meeting
12 noon	Board of Trustees Meeting
	MMPAC Membership Meeting
	Young Physician's Section (YPS) Business Meeting
	Information & Quality Healthcare (I.Q.H.) Annual Meeting
2:00 p.m.	Reference Committee on Constitution and Bylaws
2:30 p.m.	Reference Committee A
4:00 p.m.	Reference Committee B
7:00 p.m.	President's Reception
9:00 p.m.	Southern Medical Association Coffee and Dessert Party

SATURDAY, MAY 20

7:00 a.m.	Specialty Society Breakfast: Mississippi Section of the American College of Obstetricians and Gynecologists
7:30 a.m.	Registration Continental Breakfast with Exhibitors

7:30 a.m.	Board of Trustees Meeting Specialty Society Breakfast: MS Chapter of the American College of Surgeons
	Past President's Breakfast
	Fifty-Year Club Breakfast
8:30 a.m.	Plenary Session
	Alliance Welcome and Coffee
9:00 a.m.	Alliance House of Delegates Meeting
	MS State Dermatology Society Meeting
11:00 a.m.	Preview Art for AMA Foundation Auction
11:30 a.m.	Committee on Publications Lunch Meeting
	MPCN Board of Directors Meeting
	Specialty Society Luncheons: MS Chapter of the ACEP
	MS Academy of Family Physicians
	MS Chapter of the American College of Surgeons
	MS State Dermatology Society
	Women in Medicine Lunch Meeting
12:00 p.m.	Alliance Luncheon / Installation of Officers
1:00 p.m.	Plenary Session
4:00 p.m.	Component Society Caucuses Central Medical Coast Counties Singing River
5:30 p.m.	University of MS Alumni Reception
6:30 p.m.	MSMA President's Inaugural Celebration
	MSMA/MSMA Alliance Reception and AMA Foundation Silent Auction

SUNDAY, MAY 21

7:00 a.m.	Board of Trustees Meeting
7:30 a.m.	Registration
	Continental Breakfast for Members
8:00 a.m.	Worship Services
8:30 a.m.	Alliance Past-Presidents' Breakfast
9:00 a.m.	House of Delegates
11:30 a.m.	Board of Trustees Meeting
11:30 a.m.	Mississippi Association of Pathologists Lunch / Meeting
12 noon	Board of Trustees Luncheon

“MEDICAL AFFAIRS FORUM 2000”

PLENARY SESSION SCHEDULE

SATURDAY, MAY 20 • MAGNOLIA BALLROOMS E-H

8:30 A.M. “LITIGATION STRESS OR WHY ME, LORD?”

- Whitman B. Johnson, III, Esq.

Currie, Johnson, Griffin, Gaines & Myers

Sponsored by the Medical Assurance Company of Mississippi (MACM)

9:45 A.M. “MEDICAL STAFF BY-LAWS: THE GOOD, THE BAD AND THE UGLY”

- Anne M. Murphy, JD, Vice President,

Health Law Division,

American Medical Association

11:30 A.M. LUNCH BREAK

1:00 A.M. “HEALTH CARE LEGISLATION AND THE 107TH CONGRESS”

- Mr. Julius Hobson, Director of Congressional Affairs,
American Medical Association

2:00 P.M. “CHEMICAL IMPAIRMENT AND THE MISSISSIPPI RECOVERING PHYSICIANS PROGRAM” (MRPP)

- Gary Carr, M.D., Medical Director,
Mississippi Recovering Physicians Program

- C. Chapman Sledge, M.D., Medical Director,
Pine Grove Recovery Center

3:00 P.M. “OPHTHALMOLOGY UPDATE: LASIK (LASER ASSISTED IN SITU KERATOMILEUSIS) AND INTACS™ (CORNEAL RING SEGMENTS)”

- Connie McCaa, M.D., Director of Corneal Services
Professor, School of Medicine
University of Mississippi (UMC) Medical Center

- Robert A. Mallette, M.D.

4:00 P.M. ADJOURN

**PLENARY PROGRAM PLANNED BY MSMA'S:
COUNCIL ON SCIENTIFIC ASSEMBLY**

TECHNICAL EXHIBITS

MSMA 132nd Annual Session

EXHIBITORS (as of JOURNAL MSMA Press Date)

Abbott Laboratories
American Academy of Physician Assistants
Ameripath
Batist Health Systems
Chandler-Sampson Insurance, Inc.
Coastal Insurance Enterprises, Inc.
Doctors Insurance Reciprocal
Executive Planning Group
Health Link
Health System of MS
Horne CPA Group
Information & Quality Healthcare (I.Q.H.)
Medical Assurance Company of Mississippi
Merck Human Health Division
Mississippi Physicians Care Network
MS Health Sciences Information Network
MS Rehab Partners
MS State Department of Health
MSMA Benefit Plan& Trust
Pine Grove
Pfizer, Inc.
UAB Health System
United HealthCare
U. S. Air Force Reserve
Wallace Laboratories



Mississippi State Medical Association Alliance

**77th Annual Session
May 18-21, 2000
Beau Rivage Resort
Biloxi, MS**

THURSDAY, MAY 18

1:00 PM - 4:00 PM

Registration

FRIDAY, MAY 19

8:00 AM - NOON

11:00 AM

6:30 PM

Registration

Pre-convention Board Meeting/Luncheon

MSMA President's Reception

SATURDAY, MAY 20

8:30 AM

9:00 AM

12:00 AM

2:00 PM

6:30 PM

Alliance Welcome and Coffee

House of Delegates

Luncheon/ Installation of Officers

Post-convention Board Meeting

MSMA/ MSMAA Membership Reception

& AMA Foundation Auction

MSMA President's Inaugural Celebration

SUNDAY, MAY 21

8:30 AM

MSMAA Past Presidents' Breakfast

You are cordially invited to the
Mississippi State Medical Association
and the
Mississippi State Medical Association Alliance's
1st Annual Favorite Mississippi Artists Show and Sale

Saturday, May 20, 2000
The Beau Rivage
Mississippi Gulf Coast
Starting at 11 o'clock a.m.
Magnolia Ballroom A

Silent Auction Format
Closed to the Public

All net proceeds go to benefit The University of Mississippi Medical Center
earmarked for educational assistance, excellence programs, and research grants
through the AMA Foundation.

Artists Showing:
(* = Will Be Present)

David Matthews, Bailey*	Yvonne Brown, Gulfport*	Dr. Gerald Wessler, Gulfport*
Mary Ann Barkley, Gulfport*	Joyce Bradley, Hattiesburg*	Lynn Greenroot, Jackson*
Julie White, Jackson*	Danny Brunt, Kosciusko*	Ann Jordan, Kosciusko*
Rebecca Broom, Madison*	Hebert & Wyatt, Madison*	Pat Odom, Ocean Springs*
James Pitts, Oxford*	Kit Fields, Ridgeland*	Mark Millett, Ridgeland*
Sara Frances Hardy, Tupelo*	Cathy Tuminello, Vicksburg*	Chester Martin, Vicksburg*
Pat Walker Fields, Vicksburg*	Ann Biedenharn Jones, Vicksburg*	
Mary Elsa Hocker, Vicksburg*		

Janie Davis, Brandon	Amy Giust, Hattiesburg	H. C. Porter, Jackson
Pete Halverson, Jackson	Sudie Manning, Jackson	Dee Dee Baker, Jackson
Yvette Sturgis, Jackson	Carolyn Pate, Madison	Elizabeth Pajerski, Vicksburg

**Tickets for the 6:30 p.m. Black Tie Dinner Gala
and Miss Americas' Entertainment available for \$30/person.
Bidding/Art show ends at conclusion.**

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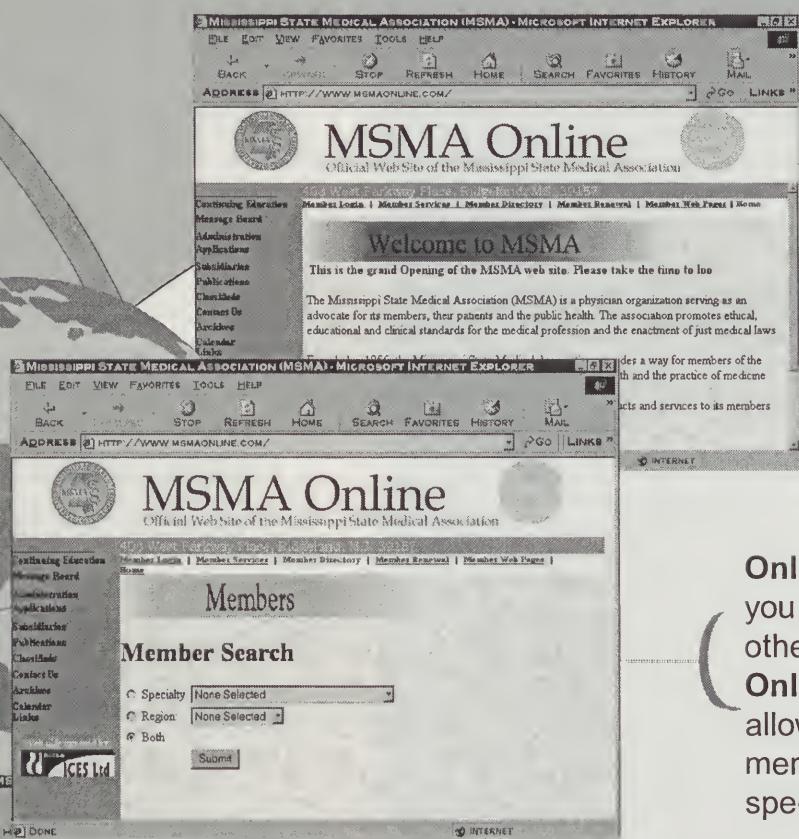
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Cover photo: Dr. James H. Johnston, III, M.D., a Jackson gastroenterologist, took this photo of a Green Heron (*Butorides striatus*). Common and locally abundant at the Ross Barnett Reservoir, the Green Heron looks more blue than green. Rapid in flight with deep wingbeats, it is told by its small size, dark underparts, and bright orange or yellow legs. Also known as a Green-backed Heron, its neck is comparatively shorter than that of other herons.

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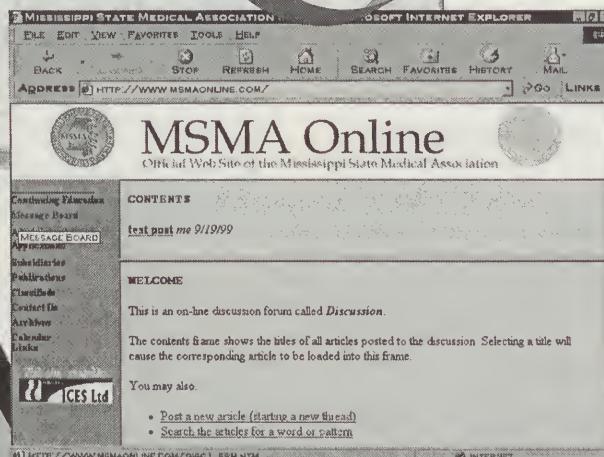
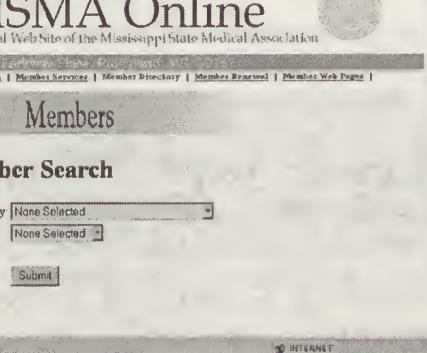
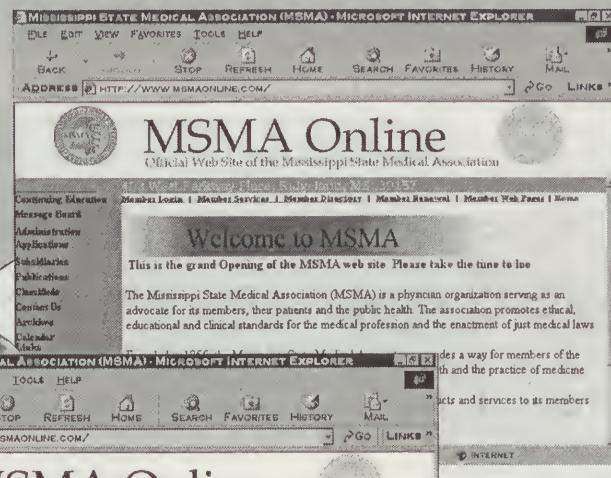
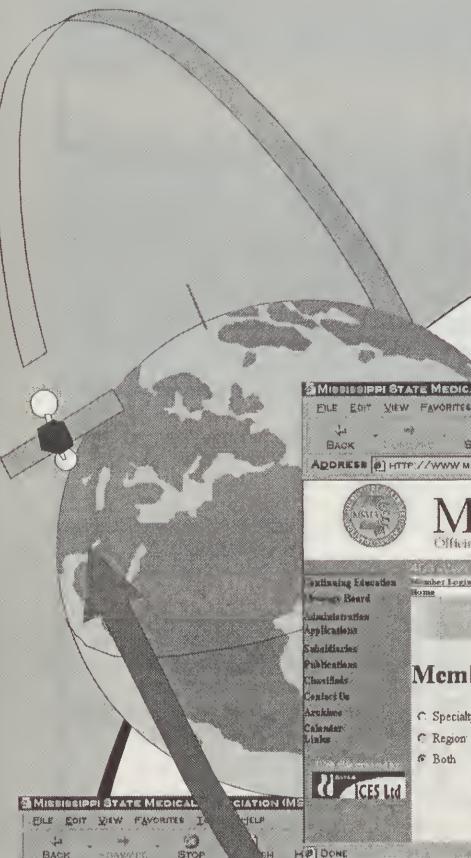
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Abstracts from the Mississippi American College of Physicians Associates' Program

The following abstracts were presented at the Mississippi American College of Physicians Associates' Annual Program held in Jackson, November 19, 1999. There were 10 oral presentations and 5 poster presentations. Here, the JOURNAL MSMA presents the 15 abstracts. —ED.

NON-HODGKIN LYMPHOMA PRESENTING AS OBSTRUCTIVE UROPATHY IN AN AIDS PATIENT

David Bahrami, M.D.(Associate)

Errol D. Crook, M.D.

Department of Medicine

University of Mississippi Medical Center and

Jackson VAMC,

Jackson, Mississippi

Non-Hodgkin lymphomas are a heterogeneous group of disorders characterized by malignant proliferation of B or T lymphocytes. We present a case of Non-Hodgkin lymphoma in a patient with AIDS who presented with acute renal failure.

Case: The patient is a 40 year old black male with AIDS diagnosed in 1989 who presented to a local hospital complaining of increased abdominal girth, constipation, and rectal bleeding for 3 weeks. He also complained of bilateral lower extremity and scrotal edema. He denied fever, chills, night sweats, nausea, vomiting, and melena. Labs revealed a BUN of 35 mg/dl and creatinine of 3.0 mg/dl (baseline Cr=1.0 mg/dl). The patient had an abdominal CT Scan that revealed a mass surrounding the urinary bladder and rectal vault with mild to moderate hydronephrosis. There was a small amount of fluid around the liver and the spleen. He was subsequently transferred to VA Medical Center for further care.

PHYSICAL EXAM: T97.4, P107, RR 18, BP 122/66. He was in no acute distress and fully oriented. HEENT; benign. No lymphadenopathy noted. CV:

tachycardic, regular, no murmurs. The chest was clear to auscultation bilaterally. Abdomen was tender, distended, with hypoactive bowel sounds. A mass was palpated in right lower quadrant extending to the umbilicus. There was shifting dullness and a fluid wave. No guarding or rebound was appreciated. There was no hepatosplenomegaly. Extremities had trace bilateral pitting edema and there was a diffuse macular, papular rash on the chest. Rectal exam was significant for diffuse tenderness to palpation and soft tissue swelling. Fecal occult blood was positive.

LABORATORY DATA: CBC: WBC= 6300 with 46.9 % segmented neutrophils; hematocrit of 32.8 %; and normal platelets. Serum chemistry: Na 139 mg/dL, K 4.7 mol/L, Cl 109 mole/L, HCO₃ 20.5 mol/L, BUN 29 mg/dL, Cr 2.1 mg/dL, glucose 91 mg/dL, Ca 8.5 mg/dL, albumin 3.0 g/dL, Mg 1.0 meq/L, PO₄ 4.5 g/dL, alkaline phosphatase 106 U/L, total bilirubin 0.2 mg/dL, ALT 171 U/L, AST 174 U/L, amylase of 58 U/L, and lipase of 148 U/L. LDH 1828 U/L. Urine Analysis revealed 2+ protein, few hyaline casts, 1-4 granular casts, 2+ bacteria, 4-8 WBC's, and 1-4 RBC's. Renal sonogram revealed mild to moderated bilateral hydronephrosis. Right kidney measured 11.4 cm and the left kidney was 11.8 cm. Abdominal CT Scan revealed abnormal soft tissue projecting in the retroperitoneum extending from caudal aspect of the kidneys into the pelvis. The rectum also showed increased soft tissue density and a mass could not be excluded.

Course: A diagnoses of obstructive uropathy secondary to a mass was made. The patient underwent CT guided fine needle aspiration of the abdominal mass

that revealed a large cell poorly differentiated Non-Hodgkin lymphoma. He had worsening of his renal function with his BUN increasing to 88 mg/dL and Cr to 5.7 mg/dL. Attempts to place bilateral ureteral stents were unsuccessful as were attempts at percutaneous nephrostomy tubes. The patient subsequently required hemodialysis. He received chemotherapy with cyclophosphamide, doxarubicin, vincristine, and prednisone. The abdominal mass responded to this treatment with decrease in size and the lactate dehydrogenase levels. He required mechanical ventilation after the development of mental status changes and respiratory distress. He recovered after a long intensive care stay. With tumor regression he had resolution of his renal failure and a repeat renal sonogram revealed decreased hydronephrosis.

Discussion: Exposure to toxic chemicals, chemotherapeutic or immunosuppressive agents, or ionizing radiation have been demonstrated as causative agents in Non-Hodgkin's lymphoma. HIV is also a clear risk factor as demonstrated in our patient. In AIDS there is an increased incidence of lymphoma, often at unusual sites such as the central nervous system or the GI tract. This case illustrates that abdominal masses may cause obstructive uropathy and Non-Hodgkin's lymphoma should be in the differential of AIDS patients presenting with acute renal failure, specifically in cases due to obstruction.

HOW COMMON IS PSEUDOHTERTENSION IN ESRD PATIENTS?

Anita Basu, M.D.

Robert Hester, M.D.

Edna Curry, R.N.

Ralph Didlake, M.D.

John Bower, M.D.

Abdulla Salahudeen, M.D.

**Department of Medicine, Physiology and Surgery,
University of Mississippi Medical Center,
Jackson, Mississippi**

Pseudohypertension, defined as blood pressure estimated with a sphygmomanometer of 10 mm or more above the true arterial pressure, has been reported in elderly, diabetics and End Stage Renal Failure (ESRD) patients. ESRD patients are prone to accelerated atherosclerosis and vascular calcification, factors that favor pseudohypertension. But the prevalence rate of

pseudohypertension among ESRD patients is not known. An unusually high prevalence rate of hypertension has been recently reported in our population. To find out whether this is in part due to a high rate of pseudohypertension, the cuff pressure using a mercury sphygmomanometer and direct intraarterial pressure were simultaneously determined in 16 of our patients with ESRD. Thirteen patients were on hemodialysis for 34 ± 15 (mean \pm SEM) months and 3 were about to start hemodialysis. Mean age was 46 ± 4 years, hypertension was reported as the cause of renal failure in 11 and diabetes mellitus in 5, and 14 patients were Afro-Americans and the 2 were Caucasians. The mean calcium-phosphate product was 43 ± 4 mg/dl, and all the patients were on antihypertensive medications. Although the mean cuff MAP was lower than the intra-arterial pressure (106 ± 5 vs. 115 ± 4 mm Hg, $P < 0.05$), 3 out of 16 (19%) patients had a cuff diastolic pressure of more than 10 mm Hg of the intra-arterial pressure, meeting the criterion of pseudohypertension. Our data suggests that pseudohypertension might not be uncommon in ESRD population and its presence might account partly for the unusually high prevalence of hypertension reported in ESRD population.

A YOUNG WOMAN WITH SEVERE HYPERCALCEMIA

Steven Clark, M.D.

Stephanie Elkins, M.D.

Bernadette Deogaygay, M.D.

Mahmoud Salem, M.D.

**University of Mississippi Medical Center,
Jackson, Mississippi**

A 31 year old African-American female with no significant medical history presented with complaints of diffuse muscle aches that progressively worsened over several weeks. Her initial electrolyte panel revealed renal insufficiency with a creatinine of 3.4 and hypercalcemia with total calcium of 20 at the outside hospital. CBC showed the white count to be 18 thousand with 82% neutrophils, 1% bands, 13% lymphocytes and 4% eosinophils. Her hematocrit was 30 with normal indices. Her hypercalcemia and renal insufficiency were treated with normal saline and Pamidronate was added after little response to fluids occurred. While hypercalcemia was treated a search for the etiology was initiated with a differential diagnosis that included

hyperparathyroidism, sarcoidosis, myeloma, or other malignancy. Parathyroid hormone levels were within the low range of normal at 16 pg/ml. Plain films of the hands revealed no characteristic osteopenia but bone survey revealed diffuse, severe, mottled osteopenia of the skull with similar but less severe findings on the iliac wings, distal ribs, and clavicles. Parathyroid hormone-related peptide was found to be 3.3 with normal being 1.4. A search for malignancy ensued with CT scans of the chest, abdomen, and pelvis revealing no malignancy or pathologic lymph nodes. Severe mottled osteopenia of the skull was again noted on CT of the head. The patient's hypercalcemia resolved, white count decreased, and renal function improved. She was discharged to return for completion of remaining evaluation as an outpatient. She returned in one week with a calcium of 21, a white count of 31, and a right-sided Bell's Palsy. Hypercalcemia was difficult to reduce despite use of fluids, Lasix, Pamidronate, Mithramycin, and Prednisone. CBC and differential on this admission revealed a lymphocytosis with atypical lymphocytes. Bone marrow aspirate was negative. However, immunophenotyping revealed T-lymphocyte clonal cells and HTLV-1 antibody was positive. She was started on CHOP chemotherapy with follow-up managed by the Hematology Division.

Adult T-cell leukemia/lymphoma is caused by the retrovirus HTLV-1 and shows diverse clinical features including lymph nodes (60%), skin lesions (39%), hypercalcemia (32%), hepatosplenomegaly (22%), and various somatic complaints. Four subtypes of ATLL include acute, chronic, smoldering and lymphoma types all resistant to chemotherapy.

RECURRENT PARATHYROID CARCINOMA PRESENTING AS A SOLITARY CEREBRAL METASTASIS

Suzanne Dater, M.D.
Thomas Alexander, M.D.
Donald McLain, M.D.
Department of Medicine,
University of Mississippi Medical Center,
Jackson, Mississippi

Parathyroid carcinoma is uncommon. However, when it occurs, it is frequently recurrent and metastatic. Metastatic sites are common to lymph nodes, lung, kidney, bone, and liver. Metastasis to the brain is rare. A Medline literature search yielded only one other case of

reported parathyroid carcinoma with metastasis to the brain.

Case: A 45 year old African-American male initially presented in 1994 with weight loss, constipation, polyuria, and left hip pain. His serum calcium level was 16 mg/dl and an intact parathyroid hormone (PTH) level was 1800 pg/ml. At parathyroid resection, he was found to have parathyroid carcinoma invading the capsule and infiltrating the skeletal muscle. Metastatic work-up was otherwise negative and he underwent radiation therapy to the neck with 4500 cG radiation. His post-op calcium levels were normal and intact PTH level was 245 pg/ml.

He was lost to follow-up until he presented to clinic December 2, 1998 with a three-week history of progressive right lower extremity weakness, abdominal pain, and weight loss. His serum calcium was 15.2 mg/dl and intact PTH was 467 pg/dl. He was hospitalized and treated initially with saline diuresis and pamidronate. Serum calcium levels improved to a level of 10.3 mg/dl ten days after admission. Further work-up included computed tomography of the chest, abdomen, and pelvis, which showed no recurrent diseases in the neck, mediastinum, lung, or liver. Bone scan was done and found to be normal. To pursue his complaint of leg weakness, electromyography, and nerve conduction tests were done and excluded peripheral neuromuscular etiology for his leg weakness. Magnetic resonance imaging of the brain revealed a 3x3 cm contrast enhancing mass high in the left parietal lobe. A technetium-99m-sestamibi scan was then done with immediate and four hour delayed images of the head, neck, and upper thorax only showing uptake in the left parietal lobe corresponding to the MRI findings.

The patient was treated with decadron and underwent a parasagittal craniotomy with IRMI guidance for tumor resection on December 15, 1998. Pathology revealed fibrosis and tumor nests consistent with metastatic disease. The tissue stained positive for synaptophysin, cytokeratin, and parathyroid hormone as did the original neck mass in 1994.

He improved post-operatively with calcium levels of 9.2 mg/dl and intact PTH levels of 52 pg/dl. He had improvement but not full recovery from his right lower leg weakness.

Discussion: Parathyroid carcinoma is a slow growing tumor with high recurrence rate. It typically presents with hyperparathyroidism and severe hypercalcemia with levels over 14 mg/dl. There is also a high incidence of palpable neck mass with parathyroid carcinomas than simple adenomas.

Once clinically suspected, technetium-99m-sestamibi is a sensitive and specific test for localizing

occult parathyroid tissue.

As with the previous case report, our patient benefited from resection of the metastatic lesion both in terms of improvement of neurologic deficits as well as his hyperparathyroidism.

Recurrent parathyroid carcinoma with only a solitary cerebral metastasis is rare. Our patient presented four years after initial surgical resection of a parathyroid carcinoma with hyperparathyroidism and right lower extremity weakness. Work-up revealed only a left parietal lobe brain mass, which was found to be metastatic parathyroid carcinoma. The only other case of parathyroid carcinoma with metastasis to the brain also had local recurrence and metastasis to the lung and mediastinal nodes.

This case represents an interesting rarity that hopefully, will illustrate the possibility of parathyroid given severe hyperparathyroidism as well as an approach to work-up and treatment.

HYPONATREMIA AND DEMECLOCYCLINE

Paul Dykes, M.D.

Abdulla K. Salahudeen, M.D.

**University of Mississippi Medical Center,
Jackson, Mississippi**

Hyponatremia is a problem frequently encountered among hospital inpatients. There are numerous underlying etiologies that must be considered in the work-up of a low serum sodium. There are, depending on the underlying cause, a number of different treatment options.

In this presentation, we would like to specifically discuss hyponatremia secondary to SIADH in the setting of malignancy. Furthermore, we would like to highlight the role of demeclocycline in lowering serum sodium, using a case illustration. A 32-year old white male was admitted to our institution with a two week history of chest pain, weight loss, and hemoptysis. His wife brought him to the hospital with a chief complaint of generalized disorientation. Physical exam revealed a cachetic white male with supraclavicular adenopathy and hepatomegaly. Laboratory findings were significant for a serum sodium of 121, uric acid of 1.3, serum osmolality of 236, and urine osmolality of 237. CT of chest and abdomen demonstrated a pulmonary nodule concomitant with multiple hepatic hypodensities. Biopsy of the liver lesions was consistent with small lung cancer thus establishing the diagnosis of SIADH secondary to malignancy.

Demeocycline was initiated after fluid restriction was attempted, but unsuccessful because of noncompliance. Serum sodium levels were measured on consecutive days after initiating demeclocycline in this patient with SIADH. We were able to demonstrate that sodium levels did indeed rise in a short time after institution of demeclocycline.

Conclusion: Demeocycline is one of several different treatment options for hyponatremia. It is particularly an attractive choice of therapy for the patient unable or unwilling to comply with fluid restriction. Although not completely free of possible side effects, it can be safely and effectively used if the patient is adequately monitored, particularly in an inpatient setting.

Sources:

- (1) *Life Science* Vol 1 No. 13 (1973), pp. 1033-1040.
- (2) Castell and Spark, *JAMA*, July 19, 1965.

THE CASE OF THE CURSE

Captain Jay D. Geoghegan (Associate), Major

Kurt W. Grathwohl (Member)

Major Kevin Callerame (Member)

Keesler Medical Center,

Keesler Air Force Base, Mississippi

Case Report: A 75 yo female underwent carotid endarterectomy for high grade stenosis. The evening after postoperative extubation she was found unresponsive. Oxygen desaturation was present, with vital signs normal. Arterial blood gas showed pH 6.8 and pCO₂ 198. She was reintubated; repeat arterial blood gas showed pH 7.45 with pCO₂ 40. She awakened spontaneously, with a normal neurological examination. There was no tracheal compromise and she was placed on continuous positive airway pressure(CPAP). After re-extubation, the patient did well initially, but later became increasingly somnolent with periods of oxygen desaturation. Apnea was observed during sleep, with severe respiratory acidosis on arterial blood gas. Awakening caused resolution of somnolence and acidosis. She was started on full face mask Bilevel Positive Airway Pressure (BIPAP), experiencing minimal desaturation and apnea. Polysomnogram demonstrated severe central sleep apnea and desaturation. Brain MRI showed chronic small vessel ischemia of hemispheric white matter and brainstem. BIPAP and negative pressure ventilation failed. She then underwent tracheostomy for nocturnal

mechanical ventilation.

Discussion: Central sleep hypoventilation syndrome, also known by the eponym Ondine's Curse, is a rare disorder characterized by severe hypopnea or apnea during sleep. The congenital form of Ondine's Curse is often associated with other disorders of autonomic neurons such as Hirschsprung's disease. The acquired form has been reported in association with syringomyelia, Parkinson's disease, congestive heart failure, and cerebral atherosclerotic disease. To our knowledge, this is the first reported case presenting after a carotid endarterectomy. Although we cannot exclude mild preexisting central sleep apnea, her current state was most likely caused by small vessel ischemic disease in the perioperative period affecting the brainstem respiratory centers. Ondine's Curse should be added to the list of possible complications from carotid endarterectomy.

LEPROMATOUS LEPROSY IN MISSISSIPPI

Doug Harkins, M.D. (Associate)

Joe Files, M.D.

Elizabeth Caldwell, M.D.

Julio Cespedes, M.D.

**Department of Medicine and Pathology,
University of Mississippi Medical Center
Jackson, Mississippi**

Leprosy, or Hanson's Disease, is caused by *Mycobacterium leprae*; and although it has been clinically recognized for thousands of years, it remains one of the major unconquered infectious diseases on a worldwide scale. For the most part, this disease has been relegated to third world countries; however, as immigration and world travel have increased, so has the incidence of leprosy in the United States and Western Europe. Most physicians in the United States possess little knowledge of this disease despite its increase in frequency; and as with other Mycobacterial diseases, leprosy can be easily misdiagnosed. Therefore, it is imperative that we as physicians improve our ability to recognize this disease.

Our patient is an 85 year old man who presented to our Hematology clinic for evaluation of chronic thrombocytopenia which had been present for four years. He had no bleeding tendencies despite a platelet count of 40,000 over the past four years. The patient reported mild hand and facial edema as well as hypersensitivity of his hands, but was otherwise without complaint. Past history is significant for diabetes, hypertension, and a chronic skin condition, which had been labeled psoriasis. His skin had

not been biopsied, but was treated with PUVA without improvement. The patient denied alcohol abuse or tobacco use. He is retired from his career as owner and operator of a lumber yard, and denies travel outside the United States.

Physical exam is remarkable for marked splenomegaly, and a diffuse erythematous blanchable macular rash over his entire body. There were no anesthetic areas to his rash. All laboratory studies except platelet count were essentially normal. His platelet count was 72,000 with an MPV of 12.3. Serum and urine protein electrophoresis were also normal. CT scan of the chest and abdomen revealed only splenomegaly without focal defects.

At this point in his workup, it was felt that our patient had a cutaneous T-cell Lymphoma, and both a skin biopsy and bone marrow biopsy were performed. To our surprise, no malignant cells were detected; however, numerous AFB were seen clustered around nerve endings on the skin biopsy, but none in the marrow. A *Fite* stain was then done on both specimens. This special stain was able to detect the acid fast bacilli in the marrow, which had eluded our routine acid fast smear. Our patient had extensive infestation with *Mycobacterium leprae*, and involvement of the spleen, which resulted in his splenomegaly and thrombocytopenia.

Our patient was referred to the national leprosarium at Carville, LA, and started on three drug therapy consisting of Dapsone 100 mg, Rifampin 600 mg, and Clofazimine 50 mg daily. He will have to continue this therapy for two years, after which he will be followed on an annual basis for relapse. Although the most common route of spread is person to person contact, his family members and close contacts are all asymptomatic at this point. They will continue to be observed for development of any skin lesions, but no prophylactic therapy is warranted.

PRIMARY AMYLOIDOSIS PRESENTING AS NEPHROTIC SYNDROME WITH DIARRHEA AND WEAKNESS

W. Dwight McComb, Jr., M.D.

Brendan S. Ross, M.D.

**University of Mississippi Medical Center
Jackson, Mississippi**

The term amyloidosis describes a spectrum of diseases involving the pathologic deposition of the fibrous protein amyloid in one or more sites in the body.

The overall incidence of primary amyloidosis, the most common type, is only 10 cases per million person years. The following describes a classic case of primary idiopathic amyloidosis.

A 57 year old male with a history of gastric carcinoma and Billroth II procedure 12 years prior presented to clinic with a four month history of weakness, weight loss, diarrhea, and increasing abdominal girth. Physical examination revealed profound scrotal and lower extremity edema. His abdomen was protuberant and diffusely tender without hepatomegaly. Reflexes were symmetrically diminished throughout. Routine laboratory workup demonstrated a mild normocytic anemia, profound hypoalbuminemia, and heavy proteinuria with normal BUN and creatinine. Serum total calcium, creatine kinase, and aldolase were normal. Electrocardiography showed low voltage in all leads, but an echocardiogram revealed no pericardial effusion. Computed tomography revealed bilateral pleural effusions, thickening of the small bowel wall and a large gallstone but no detectable masses or significant ascites. Thoracentesis produced a transudate with negative cytology, and electromyography and nerve conduction studies showed only severe nonspecific axonal neuropathy. Serum and urine protein electrophoresis revealed a nonselective polyclonal pattern consistent with nephrotic syndrome. Renal ultrasound showed increased echogenicity suggesting parenchymal disease.

A kidney biopsy was performed on hospital day #8. Congo red stain was positive, revealing advanced glomerular amyloid deposition that was lambda light chain restricted by subsequent immunofluorescence. Urine immunofixation detected no monoclonal component, but urine immunoelectrophoresis showed a faint monoclonal band of lambda light chains. Myeloma was ruled out based on the clinical picture: the patient had no bone pain or plasmacytosis, normal serum calcium, and no serum monoclonal spike. Based on this information, a diagnosis of idiopathic primary amyloidosis was made.

The current classification system for systemic amyloidosis is based on the biochemical composition of the amyloid fibrils. Primary amyloidosis (AL) is caused by the tissue deposition of whole or fragmented immunoglobulin light chains. It is idiopathic 80-90% of the time, with 10-20% resulting from multiple myeloma. Common presenting complaints include weakness, fatigue, weight loss, dyspnea, edema, and syncope. Clinical findings include nephrotic syndrome, congestive heart failure, carpal tunnel syndrome, peripheral neuropathy, orthostatic hypotension, and gastrointestinal disturbances. Diagnosis begins with identification of amyloid fibrils in biopsy sections of affected tissues, but classification

requires immunohistochemistry staining and correlation with protein studies. Serum protein electrophoresis (PEP) may show a monoclonal spike, and urine PEP often reveals a free light chain (Bence Jones protein) spike. Immunoelectrophoresis and immunofixation increase sensitivity for detection of free light chains. The prognosis for AL amyloidosis is poor, with a mean survival of 12 months. Treatment is primarily supportive. The current therapy of choice is a combination of prednisone, melphalan, and colchicine. Organ transplantation is another viable alternative.

HEPATITIS C (HCV) INDUCED RHEUMATIC DISEASE

Capt. Eric A. Meier (Associate)

John Huntwork, M.D.

Maj. Matthew T. Carpenter (FACP)

Keesler Medical Center,

Keesler Air Force Base, Mississippi and

Singing River Hospital,

Pascagoula, Mississippi

Background: Autoimmune disorders have been associated with HCV infection in the last few years but clear cause and effect relationship has not been established. The results of therapy with interferon for these syndromes is not well described.

Method: 5 cases of autoimmune disorders associated with HCV infection were retrospectively reviewed for clinical features, laboratory findings and the effect of treatment with interferon.

Results: 4 patients were female (3 Caucasian and 1 African American); 1 was male (Caucasian). Mean age was 44 years (range 41-51 years). All patients had a diagnosis of chronic HCV. The autoimmune diagnoses were: 1) 42 yo female with SLE; 2) 45 yo male with RA; 3) 51 yo female with type II mixed essential cryoglobulinemia; 4) 43 yo female with type II mixed essential cryoglobulinemia; 5) 41 yo female with overlap RA/SLE. All patients had positive ANA and RF; 4 had positive cryoglobulins. 1 patient had decreased C3 and C4; 3 had decreased C4 and 1 had normal complement levels. All 5 were treated with interferon. Follow up was available on 4 patients. Viral RNA levels decreased in all patients. All had subjective improvement in their rheumatic symptoms; 3 improved in their clinical examination. ANA, RF and complements normalized except 1 patient with cryoglobulinemia still had depressed C4.

Discussion: In chronic HCV infection antigenemia persists. Immune complexes composed of HCV antigens and antibodies, RF and C3 may be formed and deposit in the liver, skin, kidney or other organs. If these immune complexes are the mechanism for development of rheumatic syndromes in HCV infection, treatment of HCV should relieve symptoms.

Conclusions: Interferon therapy is an effective treatment for HCV induced rheumatic disease. The favorable response to therapy implies a causal role for HCV infection in these syndromes.

LACTIC ACIDOSIS SECONDARY TO METFORMIN IN TWO PATIENTS WITH RENAL DYSFUNCTION

John M. Nipper, M.D.
Edith M. Simmons, M.D.

Errol D. Crook, M.D.

University of Mississippi Medical Center and
VA Medical Center,
Jackson, Mississippi

Metformin is a biguanide oral hypoglycemic agent commonly used in the management of non-insulin-dependent diabetes mellitus (NIDDM). It has been associated with a risk of severe lactic acidosis, usually in patients with contraindications to its use, most often renal insufficiency. We describe two such cases, one in an end-stage renal disease (ESRD) patient and one in a patient with milder renal insufficiency.

Case 1. A 75-year-old black man with ESRD secondary to diabetes and hypertension on dialysis for 4 years was started on metformin within 4 months of presentation. He experienced two weeks of nausea, vomiting, and a progressive decline in overall alertness before experiencing new onset of a seizure during dialysis. Laboratory evaluation revealed a high anion gap (AG) acidosis with a pH of 7.1 and elevated lactate levels which were persistent despite hydration and absence of further seizures. With further dialysis, bicarbonate administration, and discontinuation of metformin his acidosis was corrected and he survived.

Case 2. A 71-year-old black man with diabetes mellitus managed with NPH insulin and metformin with a historic baseline creatinine of 1.5 (calculated creatinine clearance = 63) was witnessed to collapse at home and presented with sustained confusion and combativeness.

Initial neurologic exam was otherwise nonfocal and CT brain was normal for age. Further evaluation revealed a creatinine of 2.5 (calculated creatinine clearance = 38) and a high AG acidosis with a pH of 7.1. Early lactate levels were high and progressively worsened. The patient's hospital course was complicated by aspiration pneumonia followed by sepsis to which he succumbed on day 6.

Discussion. Though the incidence of metformin-associated lactic acidosis is low (approximately 0.03 cases/1000 patient years) it has an associated mortality rate of approximately 50%. Most such cases occur in patients with contraindications to the use of this drug. Metformin is not metabolized and is dependent on renal excretion for clearance. Settings where drug is accumulated in excess may result in lactic acidosis. Specific contraindications include any renal insufficiency as suggested by a serum creatinine greater than 1.5 in men, 1.4 in women, or in situations of decreased renal perfusion such as many acute illnesses, dehydration, or with the use of radiologic contrast. Patients in whom metformin is to be used should be evaluated for any contraindication and monitored for deterioration of renal function during therapy. Any episode of acidosis should be evaluated specifically for lactic acidosis. Metformin drug levels may also be of use in this setting. Early recognition and treatment is essential given the high associated mortality rate.

EXTRAMEDULLARY HEMATOPOIESIS AND THALASSEMIA INTERMEDIA ASSOCIATED WITH COMPOUND HETEROZYGOSITY FOR THE -532 DEL b THALASSEMIA AND HEREDITARY PERSISTENCE OF FETAL HEMOGLOBIN (HPFH)-2

Guangzhi Qu, M.D., Ph.D.
Martin H. Steinberg, M.D.
Department of Medicine,
University of Mississippi Medical Center and
VA Medical Center,
Jackson, Mississippi

HPFH is characterized by fetal hemoglobin levels (Hb F) between 15% and 30% and normal red cell indices. b thalassemia, another heterogeneous group of globin gene mutations causes hypochromia, microcytosis and hemolytic anemia. Only a few compound heterozygotes for gene deletion or non-gene deletion HPFH and b°

thalassemia have been reported and they have a phenotype of thalassemia trait with high Hb F (>60%) and microcytosis. We studied an American-African man with anemia and unusual symptomatic extramedullary hematopoiesis who is a novel compound heterozygote for HPFH-2 and a rare deletional b thalassemia. This 42-year-old man was evaluated for numbness and weakness of his legs. On physical examination, he had generalized lymphadenopathy, marked splenomegaly and leg ulcers but lacked the bony changes typical of B thalassemia. His HT was 29, MCV 66, and reticulocytes 3.1%. Hemoglobin electrophoresis revealed 6.9% HbA₂ and 87.7% Hb F. Unconjugated bilirubin was 3.7 mg/dL. Computed tomography displayed multiple paraspinal masses and an 8x5x5 cm large lobulated presacral mass. By magnetic resonance imaging, the sacral mass followed the bone marrow signals, displacing the neuromuscular bundle laterally. A lymph node biopsy revealed hematopoietic tissue. Polymerase chain reaction (PCR) was used to detect a 105-kb deletion in the b-globin gene cluster consistent with HPFH-2 and a 532-bp deletion in the 5' region of the b-globin gene, previously described in a cousin (Waye et al, Blood, 77, 1100, 1991). This 532-bp deletion, which includes the translation initiation site and part of the gene promoter, is associated with uncommonly high levels of Hb A2, perhaps because of increased interaction of the LCR and transcription factors with the remaining d-globin gene promoter. a-globin gene mapping showed normal sized a-globin gene fragment after digestion with Bam HI and Bgl II and hybridization with a-globin gene-specific probe. Family studies indicated that the mother and two sisters of the proband, all with Hb F of 20% and near normal red cell indices, were heterozygotes for HPFH. The daughter of the proband had microcytic anemia and Hb A₂ of 7.7% and was heterozygous for b thalassemia. Since the usual phenotype of compound heterozygotes for gene-deletional HPFH and b thalassemia is that of b thalassemia trait, it is unclear why our patient has symptomatic b thalassemia intermedia.

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MUCOSA ASSOCIATED LYMPHOID TISSUE (MALT) LYMPHOMA PRESENTING AS RECURRENT PANCREATITIS

Capt. MDW Schott

Maj. M Lievens

Maj. R Locicero

Maj. M Carpenter

Keesler Medical Center,

Keesler Air Force Base, Mississippi

Case Report: A 61 yo man presented for ERCP after two hospitalizations for acute pancreatitis within the previous 6 months. Symptoms included LUQ abdominal boring pain unaffected by food, anorexia, 10 pound weight loss and fatigue. He denied use of ethanol. Physical examination revealed only mild epigastric tenderness. CBC, ESR, chemistries, liver enzymes, lipase and TSH were normal; amylase was 170 (30-110). Ultrasound revealed a thickened gall bladder without stones or ductal abnormalities. Abdominal CT scan was completely normal. ERCP found a 2.5 cm mass involving the ampulla of Vater causing mild dilation of the pancreatic ducts. Also seen was a distal 2 cm long stenosis of the common bile duct. Sphincterotomy and stent placement were performed. Biopsy returned positive for low grade MALT lymphoma. Bone marrow biopsy demonstrated that over half the marrow elements consisted of small lymphocytes distributed diffusely and in aggregates, designating the patient as stage IV. Treatment was initiated with CHOP chemotherapy.

Discussion: MALT lymphoma is an uncommon form of non-Hodgkin's lymphoma (NHL), arising from marginal zone B-cells. Approximately 50% of MALT lymphomas arise in the GI tract, with the remainder occurring at various extranodal sites. Pancreatic involvement is quite rare and our literature review found no other cases of ampullary MALT lymphoma. Prognosis of MALT lymphoma is more favorable than other varieties of NHL; MALT lymphoma arising at GI sites tends to have slower time to disease progression than non-GI sites. Poor prognostic features include abdominal or thoracic lymph nodes, decreased albumin and anemia. Stage IV lymphoma is incurable, but radiation and chemotherapy can be palliative. Although B symptoms are not unusual, our case is unique in that the patient presented with recurrent pancreatitis.

SPONTANEOUS GASTRIC PERFORATION IN AN INFANT

Manisha Sethi, M.D.
Richard Boyte, M.D.
Phyllis Bishop, M.D.
Mike Nowicki, M.D.
Paul Parker, M.D.
University of Mississippi Medical Center
Jackson, Mississippi

A gastric perforation in infancy is a rare occurrence. The etiology is often unknown leading to the term "spontaneous gastric rupture". In a literature review, all reported cases of spontaneous gastric perforation were in infants less than two weeks of age. This case report describes a spontaneous gastric perforation in a previously healthy 16 week old infant.

T.H. was a previously healthy 16 week old Caucasian female who presented to her local pediatrician with a one day history of irritability, mild nausea, vomiting and decreased oral intake. At the physician's office, she was noted to be dehydrated and was referred to UMMC for further evaluation and fluid resuscitation. Upon arrival at UMMC, pertinent physical exam findings included an infant in acute distress with cyanotic extremities, sunken fontanelle, nonpalpable pulses, grunting respirations, tachycardia and marked abdominal distention without audible bowel sounds. She required aggressive fluid resuscitation with normal saline, albumin and blood as well as infusions of dopamine and epinephrine. An abdominal film was obtained which revealed a pneumoperitoneum and the need for an exploratory laparotomy became apparent.

Intraoperative findings revealed what appeared to be formula in the peritoneal cavity without bile or stool present. Upon further investigation of the abdominal cavity, a large, superior greater curvature perforation (4 cm in length) extending from the fundus down one-third of the greater curvature was noted. The edges of the defect were necrotic and areas of the adjacent stomach were cyanotic. The necrotic areas were resected, and the perforation was repaired.

This case illustrates the serious nature of a gastric perforation. This condition is associated with an extremely high morbidity and mortality making early recognition and prompt, aggressive therapy essential. The clinical manifestations include vomiting, abdominal distention, respiratory distress, cyanosis and a rapid progression to shock. A roentgenological study of the

abdomen reveals a pneumoperitoneum with an absence of air in the stomach indicating the need for immediate surgical intervention.

A spontaneous gastric perforation in a previously healthy infant who has progressed past the immediate neonatal period has not been reported in the literature reviewed. Since Siebold reported the first case of neonatal gastric perforation in 1825, numerous theories have been proposed for possible etiologies of these "spontaneous gastric perforations". Several of these include (1) pneumatic rupture of the stomach, (2) congenital absence of the gastric wall musculature, (3) ischemia of the gastric wall secondary to vascular shunting, and (4) possible correlation between the absence of C-KIT+ mast cells in the GIT and predisposition to spontaneous perforation. This case demonstrates that spontaneous gastric perforation may occur in older infants and the necessity of early diagnosis and treatment of this often lethal condition.

WEGENER'S GRANULOMATOSIS IN A FORTY-FOUR YEAR OLD INDIAN MALE PRESENTING WITH ABDOMINAL PAIN, HEMATURIA, AND BILATERAL PULMONARY NODULES

Jimmy L. Stewart, Jr., M.D.
Marion Wofford, M.D.
Department of Medicine
University of Mississippi Medical Center,
Jackson, Mississippi

A forty-four year old Indian male presented to the emergency department with complaints of low grade fever and nonproductive cough for one week. He was noted to smoke 4-5 cigarettes a day, diagnosed with bronchitis, and treated with azithromycin. Four days later he again presented to the emergency room with constant, stabbing lower abdominal pain. His physical exam revealed a moderately tender abdomen without masses or rebound pain. Urinalysis showed microscopic hematuria. Serum chemistries were normal as was plain abdominal films. A CT of the abdomen was performed which was unrevealing for any abdominal pathology but showed bilateral cavitary nodules in the lower lobes of the lungs, the largest measuring 2.8 x 3.2 cm. A previous chest x-ray 2 months earlier was normal. He was discharged and referred to the pulmonary clinic, but was

seen in general medicine clinic and admitted for work-up of the multiple cavitary lung nodules. Upon admission, further history revealed he had been seen twice in ENT clinic for persistent otitis media and clear rhinorrhea, and was treated with fluticasone nasal spray for allergic rhinitis. He denied constipation, diarrhea, or recent TB exposures, but had immigrated from India 13 months prior and received BCG vaccination as a child. Physical exam revealed only mild left upper quadrant abdominal pain. Laboratory data were normal except for urinalysis which showed 4 WBC and 97 RBC. The patient subsequently developed fever to 102 F, melena, nausea, and vomiting. He was placed on vancomycin and ceftazidime for occult bacteremia. Tuberculin skin test was non-reactive, HIV and blood cultures negative, and echocardiography normal. A fiberoptic bronchoscopy and CT-guided fine needle aspiration of the pulmonary nodules were performed which were nondiagnostic. A renal biopsy was then obtained which showed necrotizing and crescentic glomerulonephritis, consistent with Wegener's granulomatosis. C-ANCA was strongly positive (PR-3 antibody). He was started on prednisone (1 mg/kg/day) and cyclophosphamide (2 mg/kg/day) with resolution of his symptoms.

Wegener's granulomatosis is a granulomatous vasculitis characteristically affecting both the upper and lower respiratory tracts with concomitant glomerulonephritis, but may present with vasculitis and granulomas of virtually any organ, including mesenteric vessels. Presence of C-ANCA positive PR-3 antibodies are 80% sensitive and 97% specific for Wegener's. Historically universally fatal, treatment with immunosuppressive therapy can achieve marked improvement in 90% and complete remission in 75% of patients.

VP-16 INDUCED METABOLIC ACIDOSIS IN A BONE MARROW TRANSPLANT PATIENT

**T. Young, M.D., (Associate)
C. Bigelow, M.D.
S. Elkins, M.D.
University of Mississippi Medical Center,
Jackson, Mississippi**

Etoposide, or VP-16, is a semisynthetic derivative of podophyllotoxin. Podophyllin is extracted from dried roots and rhizomes of *Podophyllum peltatum* (also known

as the May apple or American mandrake). Native Americans discovered this extract and used it as a medicinal agent and as a poison. The ability of podophyllotoxin to cause metaphase arrest led to the development of etoposide or VP-16 which is an active agent in the treatment of several human malignancies including testicular cancer, small cell lung cancer, lymphoma and acute nonlymphocytic leukemia.

Myelosuppression is the dose limiting toxicity of etoposide. Other toxicities such as nausea, vomiting, alopecia are mild or infrequent at standard intravenous doses. However, in the late 1980's total body irradiation in combination with high dose VP-16 was studied as a new preparative regimen for bone marrow transplantation. This high dose regimen is often used in patients with non-Hodgkin's lymphoma undergoing autologous bone marrow transplantation.

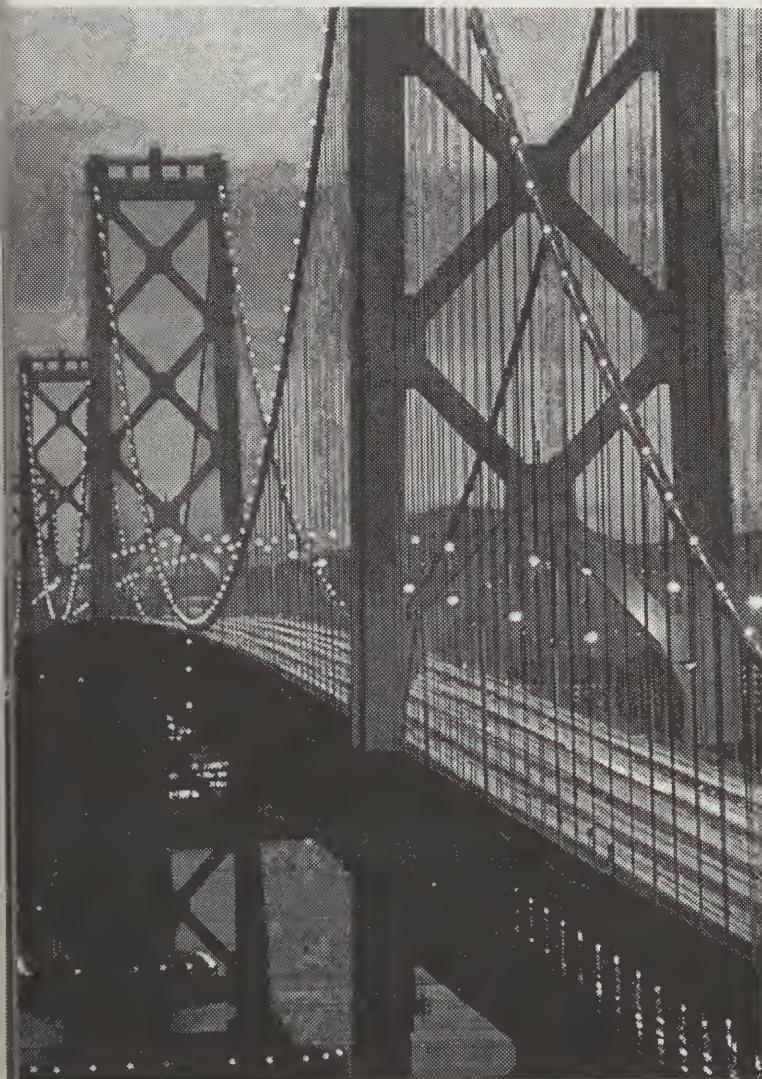
A 54 year old female with a history of relapsed non-Hodgkin's lymphoma underwent a standard preparative regimen prior to autologous bone marrow transplantation. This regimen consisted of fractionated total body irradiation for four days followed by VP-16 at 60 mg/kg IV and cyclophosphamide 100 mg/kg IV with MESNA. She tolerated total body irradiation with only mild nausea and vomiting. Approximately eight hours after receiving VP-16, our patient developed shortness of breath and chest pain. Her physical examination revealed pulmonary edema, which was confirmed by CXR. She received lasix intravenously but symptoms persisted, and arterial blood gases revealed a severe metabolic acidosis (pO₂ 157, pCO₂ 17.6, pH 6.97, HCO₃ 4.1; Anion gap - 22). The patient required transfer to the intensive care unit, but did respond to IV fluids and bicarbonate infusion.

Etoposide is not soluble in water and must be formulated in polyethylene glycol, benzyl alcohol and polysorbate 80. The 1-2 gram doses used for transplantation require a diluent volume of several liters which places patients at risk for fluid overload, thus the drug is often administered undiluted.

Consequently, when high doses of etoposide are used, polyethylene glycol and benzyl alcohol are administered in significant amounts, which can cause a severe metabolic acidosis. High anion gap metabolic acidosis is an uncommon but serious complication of high dose etoposide.

Abstracts submitted by Errol D. Crook, M.D., assistant professor of medicine, University of Mississippi Medical Center, coordinator of Associates Activities, Mississippi ACP-ASIM.

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The Mississippi Recovering Physicians Program

**Gary D. Carr, M.D.
MRPP Program Director**

In 1978, Dr. Ellis Moffitt and his wife, Nina, laid the groundwork for the program that would become the Mississippi Impaired Professionals Program, or Cadeuceus. This program has been an invaluable source of support to recovering healthcare professionals throughout Mississippi. Over the years, this program has continued to evolve. The Mississippi State Medical Association (MSMA) for many years has recognized the need to assist the sick physician. In 1997, in keeping pace with current treatment of impaired physicians, MSMA, in a contractual relationship with the Mississippi Board of Medical Licensure (BML), developed the Mississippi Impaired Physicians Committee (MIPC) to promote early identification of the physician who may be ill as the result of substance abuse, mental or emotional illness. Members of the Mississippi Impaired Physicians Committee are chosen because of their knowledge and expertise in matters involving physician impairment. MSMA's action is in compliance with a directive by the American Medical Association that all states should have such a committee.

Development of the Mississippi Recovering Physicians Program

Action taken during the 1998 regular session of the Mississippi legislature effectively vested and funded MIPC and enabled the BML to contract with MSMA and MIPC.

This contract, known as the Memorandum of Understanding, recognizes chemical dependency/alcoholism and mental/emotional disorders as treatable illnesses and provides a therapeutic alternative to the disciplinary process, in most cases. Further, the Memorandum of Understanding recognizes that impairment and recovery are mitigating factors in board disciplinary decisions and offers an incentive for early intervention and treatment. It

also provides the licensee an opportunity to continue or re-enter practice after completing any indicated treatment while participating in a documented monitoring process.

Under the direction of MSMA, the MIPC develops the policies and procedures for Mississippi's recovering physicians program, known as the Mississippi Recovering Physicians Program (MRPP). The BML provides principal funding for the activities of the MIPC and MRPP. The MIPC has directed MRPP as a full-time program since July 1, 1998. In establishing the MRPP, MSMA and the BML affirm that chemical dependency/alcoholism and mental/emotional disorder are diseases which can cause impairment, that these diseases can be successfully treated in most cases, and that, with appropriate intervention, physicians can continue or resume practicing medicine with reasonable care and safety. The MRPP process is consistent with the recommendations of the Federation of State Medical Boards' Ad Hoc Committee on Physician Impairment and meets its criteria for BML approval.

Mission Statement

The Mississippi Recovering Physicians Program is dedicated to the health of the impaired physician, the health of the physician's family and the health of the community they serve.

Mississippi Recovering Physicians Program Goal

To identify impaired physicians in the state of Mississippi, to assist them in preserving their health, and to help them continue or return to treating patients in the most effective manner.

Program Principles

1. That humanitarian concern for the public and the impaired physician motivates the program.
2. That alcoholism/chemical dependency and mental/emotional disorders are treatable illnesses.
3. That alcoholism/chemical dependency and mental/emotional disorders among physicians should not be ignored or left untreated.
4. That impaired physicians are obliged to accept help and cooperate in treatment in order to regain or retain their full effectiveness to practice medicine.
5. That impairment may be established by a physician's acknowledgment or admission or by the observance and evaluation of peers knowledgeable about these issues and/or through a formal inpatient evaluation.
6. That it is every physician's responsibility to be cognizant of any colleague's chemical dependency and/or mental illness and to assist these colleagues in receiving appropriate treatment.
7. That impaired physicians who pose a danger to patients must be reported immediately to the Board of Medical Licensure of the State of Mississippi.
8. That the recovering physician should not be punished merely on the basis of his diagnosis and that to do so impedes the recovery process.
9. That treating an impaired physician is more cost effective than training a new physician.

Scope of the Program

All Mississippi licensed physicians, residents, medical students, and podiatrists are within the scope of MRPP. The MRPP does not discriminate and will not deny services based on a physician's specialty, medical degree, membership affiliations, race, religion, national origin, disability or ability to pay. Physicians identified to MRPP are referred by fellow physicians, friends, families, hospital administrators, nurses, BML, or others. Self-referrals are encouraged. The MIPC's assistance in helping the impaired physician enter recovery can be instrumental in helping to preserve the physician's medical license/DEA, while assuring patient safety.

Some physicians identified to MRPP will be inap-

propriate referrals and will be promptly referred to the Board of Medical Licensure, others are identified with insufficient information to proceed and are placed in long-term observation.

Procedures

The following process will be used by the Mississippi Impaired Physicians Committee in dealing with impaired physicians. This process is used as a general guideline. Each separate case will dictate individual variations, and each participant should be considered separately. Nor will this process cover all contingencies that may arise.

The Mississippi Impaired Physicians Committee will provide total oversight of this process on a routine basis. Within the dictates of timeliness, the medical director will be required to implement these steps with the input of the chairman, individual committee members, or ad hoc groups of members, as individual circumstances dictate. Staff shall act as a central information-receiving and coordinating source under the direction of the chairman/medical director.

Information/Reporting

Information about suspected individuals will be received from various sources. Common recurring sources are the Board of Medical Licensure, colleagues/peers, hospital staff/administrators, coworkers, spouses, and family members. Reports made to the BML will be referred to the MIPC for action. Routinely, the information will be reported to the MRPP medical director/chairman, individual committee members or staff. Reasonable and discrete efforts should be made to acquire as much objective information as possible regarding the nature of the impairment, its manifestations, substances in question, and duration of abuse. Information received is confidential, nonpublic, and carefully maintained at all times.

Confirmation/Documentation

The medical director/chairman, committee member, or staff attempt to acquire confirmation or documentation of the reported impairment issue from the reporting source, the Board of Medical Licensure investigators, local contacts, and other credible sources. In some instances, adequate confirmation may not be obtainable, and the process may be postponed and the individual placed in "observation" until adequate documentation can be acquired. Consistent with Federation guidelines, physicians who meet one or more of the following criteria will require further evaluation/as-

essment:

1. Documentation of excessive use of alcohol/other drugs.
2. Behavioral, affective and/or thought disorders or other untreated mental, emotional or physical illness which might pose a threat to public safety.

Intervention

If the situation dictates, intervention may be arranged by the medical director in cooperation with the MIPC, family members, licensure investigators, and other principles. Some instances will not require intervention. Where intervention is appropriate, the medical director will be included or consulted.

Some issues to be explored during intervention/evaluation include:

- Does the physician have an alcohol, drug, mental or emotional problem requiring evaluation?
- Is there evidence of impairment which might impact the individual's ability to practice medicine? If so, is there evidence of imminent danger to the public which would warrant immediate notification of the Board of Medical Licensure?
 - Is there a history of previous treatment?
 - Is the physician motivated to enter or resume recovery and to participate in the Mississippi Recovering Physicians Program?
 - What is the potential for involvement by family members in the treatment process?
 - Is there imminent danger of suicide?

During the intervention, the nonpunitive nature of the MRPP, as well as, the advocacy it can provide is stressed. If necessary, the possibility of action by the BML is introduced to aid in the intervention.

Assessment and Evaluation

Depending on the situation, the medical director may arrange assessment of the individual participant by a psychiatrist, counselor, therapist, or neuropsychologist. Circumstances may require that assessment be conducted at an off-site facility on an inpatient basis, or assessments may be made by the medical director and other intervenors on the spot.

MIPC members will make themselves available for emergency evaluations.

Acute Treatment

If acute treatment is indicated, the medical director will be involved in determining arrangements for acute care in a facility jointly approved by MS BML and MIPC. In the acute treatment phases, the nature and

duration of treatment will be determined by the facility principals, and the medical director shall seek continuing information during the treatment phase. Choice of facility will be determined, in part, by coordination with the committee regarding family involvement and after-care referral.

Intensive outpatient treatment is available within our own state but generally not a viable option. Intensive inpatient and residential programs used are ones that we have found to be particularly effective and cost-efficient both in and out of state. Should inpatient evaluation be recommended by the onsite evaluating team, we have insisted that the program doing the intensive inpatient evaluation have no connection to MRPP or BML which could be construed as a conflict of interest. Treatment programs selected and offered as options will meet or exceed the criteria set forth in section IX of the Federation of State Medical Boards' Ad Hoc Committee on Physician Impairment. Any physician, whether self-referred or board mandated to MRPP, who is determined by the MIPC to be in need of treatment, but leaves treatment AMA will be reported immediately to the BML.

At the completion of any indicated treatment, the individual is enrolled in one of the MRPP therapy groups situated in various geographic locations throughout Mississippi. These facilitated therapy groups meet weekly, and the physician under contract will be involved in these groups for a minimum of 5 years.

Recovery and Monitoring

As with any successful recovery program, the basis for successful recovery involves a major spiritual component. We consider the latitude of spirituality to include Alcoholics Anonymous, Narcotics Anonymous and other 12-Step programs, which is our primary recommendation. The number of meetings attended is established by the MIPC in full concert with the recovering individual and the significant others of the recovering individual. In certain circumstances monitored recovering physicians may elect to use the church as their spiritual resource, subject to approval by the MIPC.

Aftercare

Consistent with Federation guidelines, our after-care plan and contract supports physician rehabilitation while protecting patient safety. Following acute treatment, the MIPC will be the primary determining body for continuing care. Facets of aftercare will include liaison with and routine reporting to the licensure board, either by name or number as appropriate; development

of a viable aftercare contract; involvement with a regional MRPP weekly therapy group and, if necessary, an individual therapist; arrangement for random, witnessed biological fluid testing; attendance at self-help group meetings and selection of a sponsor; selection of an approved primary care physician; and assignment of a committee member as a regular contact and practice supervisor. Routine appearances before the MIPC will be conducted at intervals dependent on the individual's progress and commitment to recovery. The physician's personal and family support system will be strongly encouraged to actively participate in the recovery process. Aftercare efforts for information exchange should be coordinated between the committee and referring hospital medical staff or other local groups.

Portability

All aftercare contracts will contain provisions to allow the MRPP to notify other applicable states Impaired Professional Programs and/or Medical Boards of the physician's participation, current status, or pending move to their state.

Advocacy

So long as the individual is compliant with the terms of the aftercare agreement and its intent, the committee shall act in a responsible manner to represent the best interest of the participant as an advocate with the licensure board, liability insurers, health insurance carriers, hospital medical staffs, managed care entities, and colleagues. This responsibility may require routine written and verbal reports on an individual's progress as well as meetings with specific agencies, such as appearances before BML on the individual's behalf.

Relapse

It is recognized that Chemical Dependency/Alcoholism are diseases and that one of their symptoms is relapse. It is further recognized that chemically dependent people may relapse in spite of monitoring efforts. This is also true in many mental illnesses. If a relapse occurs, the committee, through the medical director/chairman, or designated committee member, shall seek confirmation. As soon as is reasonable, a critical assessment of the individual's recovery program and nature of the relapse will be made and additional treatment or recovery modification will be determined. Agencies to which the committee is an advocate will be advised of the relapse and MIPC's recommendations to the relapsed physician will be communicated.

Record Maintenance

Records on each individual participant will be maintained by the committee. These records will contain clinical as well as anecdotal information and are considered the sole property of the committee. These records are not considered to be discoverable, and their use will remain at the discretion of the committee and its director within the boundaries of any legal reporting requirements. These records also may include contracts for assessment, treatment, and aftercare. Requests for discovery of these records will be given to the BML attorney for disposition.

Information Release

Excluding legal or prior contractual demands, information shall not be released to any party without the express signed consent of the individual involved. A signed general information release will be considered adequate consent except for individuals or agencies seeking only specific items of data. Anecdotal information will be released only at the discretion of the chairman/medical director, or the committee. Any information acquired without written consent of the individual shall be considered formally to be anecdotal.

Reporting Issues

Mississippi law expressly exempts the MIPC and MRPP from the requirements of a data bank report on impaired physicians who are receptive to the help we offer. MRPP reports activities to the BML, however physicians' identities are not revealed to the full board except under the following circumstances:

- The physician is referred to MRPP by the BML.
- If it is determined the physician presents an imminent danger to the public or himself.
- If the physician is believed to be impaired and refuses to cooperate with the MIPC after sufficient committee efforts.
- If, during treatment, the physician does not follow the treatment plan and/or does not respond to treatment.

Compliance

While overall recovery may be apparent, individual facets may not be quantifiable. A total recovery program, ideally, is attitudinal and cannot be objectively measured. It shall be the responsibility of the chairman/medical director, and the committee, using practical and personal experience, to define individual recovery facets and determine compliance. Compliance can be

supported through random biological fluid testing, which shall be at the individual's expense, and through reports from designated individuals within the physicians RPP group as well as other treating professionals involved with the physician's recovery. Overall compliance, however, remains a subjective determination.

Monitoring in our program consists of at least a five-year contract. Individuals may elect to continue our program, and they are invited to do so, beyond the five-year contractual period. Dismissal can occur at any time due to breach of contract or the individual's choice. If dismissal occurs, the groups with which we have advocacy relationships and the BML are notified.

OPERATIONS

Staff

Currently, our staff consists of a physician medical director with extensive addiction medicine knowledge. This is a full-time salaried position. A full-time administrative assistant will also be on staff, and a part-time employee who works at a range of jobs, dependent on case-load and available funds.

Funding

The funding for the Mississippi Recovering Physicians Program is derived from various sources. The principle funding is derived from a portion of the state license and reapplication fees generated by the Mississippi State Board of Medical Licensure. Moneys from the license fees are dispensed as a budget item of the Mississippi State Board of Medical Licensure to the MRPP through MSMA. Yearly activity and budget reports are prepared by the MRPP to the Mississippi BML and MSMA. Donations from medical malpractice groups are sought. We also seek support from state hospitals on a per bed basis. MRPP participants pay a yearly fee. Other sources of revenue will be explored.

Relationships

Our relationship with the Mississippi State Board of Medical Licensure is both a cooperative and contractual relationship born of mutual trust and the mutual desire to protect the public and see that the state has healthy physicians. The MRPP understands the licensure and disciplinary responsibilities of the BML and is committed to an open, honest, relationship which will serve the interests of the public and the recovering physician.

Our relationship with the MSMA is currently in an advisory role as a standing constituent committee. Through statute definition, we now have immunity from

discovery of records and protection in liability issues commensurate with that of the Mississippi State Board of Medical Licensure.

CONCLUSION

The emerging experience of Federation recommended impaired physicians committees nationwide, on which, the Mississippi Recovering Physicians Program was modeled, have shown very encouraging results. Currently, 90% of such program participants are in compliance with their contracts and are stable in recovery, with documentation to ensure that they are practicing medicine with reasonable skill and safety.

The Mississippi Recovering Physicians Program is a positive example illustrating that organized medicine and regulatory boards can work cooperatively to ensure the health of the impaired physician and the patients they serve. For the impaired physician, programs such as this are often able to protect the public while providing the assistance the physician needs to enter recovery without the Licensure/DEA complications and Data Bank reports which can make their professional/private life and their recovery more difficult.

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Tim C. Medley, CFP
Cecil Brown, CPA
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Coding Concepts

Wanda L. Adams, CPC

Q. We have a nurse practitioner who is trained in hypnotherapy. Can she bill for evaluation and management services or counseling based on time when she sees a patient on the same day that she does hypnotherapy?

A. CPT code 90880, Hypnotherapy includes the evaluation of the patient, induction of an altered state of conscious, and an evaluation of altering behavior patterns. If the documentation supports an evaluation for more than seeing the patient for the hypnosis or the patient has been seen and evaluated by the physician on the same date of service, you would be able to bill both an E & M service and the hypnosis. You would need to attach Modifier-25, significant, separately identifiable evaluation and management service by the same physician on the day of a procedure.

Q. What is going on with nurse practitioners and Medicare? I heard somewhere that I need to get a provider number or I may not be able to see and treat Medicare patients. Please offer insight into this situation.

A. Medicare has been reconsidering their payment guidelines for nurse practitioners. Since many NP's do not have their own pin number, claims have been filed as "incident to" using the physician's ID number. From a Medicare stand point, this has resulted in increased payments based on physicians' allowed amounts. Nurse practitioners, billing under their own pin numbers, are paid at a lower rate - usually 70 -80% of the physician fee schedule. To reduce this expenditure and identify who is actually providing services to Medicare recipients, Medicare is considering implementation of the following guidelines.

- Medicare to require NP's have a master degree. This was originally scheduled for 2001, but has been deferred until 2003.

- For 2001, to treat a Medicare patient, NP must be a registered nurse and nationally certified.

- NP's who currently have pin numbers will be "grand fathered" into the new ruling for 2001.

So what does all this mean to you or your practice, obtain and use pin numbers for NP's before the guidelines are implemented. NP's should consider registering this year with Medicare and obtaining their own pin numbers before the rules change.

Q. Please define the intended use of the surgical assistant modifiers -80 thru -82. We are having some confusion in the office as to their correct usage. Also, should the assistant complete an operative report?

A. According to the AMA, each physician should have an operative report to indicate the distinct service provided by each surgeon. However, with most insurance companies, it is sufficient for the primary surgeon to list the name of the assistant in his/her operative report - an additional report is generally not required.

As to the correct use of the surgical assistant modifiers -80 thru -82, the following information is presented based on AMA's definitions and intended application.

Modifier -80

Assistant surgeon used to report the services of another physician assisting a primary surgeon provided the assistant was present for the *entire* operation or a substantial portion of the operation.

Modifier -81

Minimum assistant surgeon used when the primary surgeon had planned to perform the procedure alone,

but due to circumstances that may arise in the course of the procedure, the surgeon requires an assistant for a relatively short time.

Modifier -82

assistant surgeon used by physicians in teaching facilities. The prerequisite for this modifier is that a qualified resident surgeon is unavailable to provide the assist. Modifier -82 indicates another surgeon (teaching physician) is assisting with the operation instead of a qualified resident surgeon.

Q. Patient was seen for a laceration that extended through the extensor and involved the PIP joint. Additionally time was spent to debride the joint and render it articulate free. Which codes would you suggest I use to best describe my services?

A. You may wish to consider the following code combinations based on the actual events of the case.

With open fracture or dislocation . . .

Code 26418 Repair, extensor tendon, finger, . . .
Code 11010 Debridement including removal of foreign material associated with open fracture

Without open fracture or dislocation . . .

Code 26418 Repair, extensor tendon, finger, . . .
Code 11040 Debridement; skin, partial thickness

CODING TIP

The old adage, "If it isn't documented - it didn't happen," is a very good rule of thumb to use when coding service or procedures. The purpose of the medical record is to document what occurred during a patient encounter. This information protects, the physician, the practice, and provides quality medical information should the records be required by another physician to treat the patient.

Do you have a question you would like answered in the Journal? Send your inquires to Wanda L. Adams, CPC, 3201 Cambridge Drive, Festus, MO 63028. Please include your name and phone number should additional information be required.

* CPT codes, copyright, American Medical Association

WHEN YOU NEED TO BE SEVERAL PLACES AT ONCE,
ISN'T IT A RELIEF TO KNOW YOUR BANK WILL BE THERE, TOO?

The frantic pace of everyday life doesn't leave a lot of time to get to the bank. No problem... if you rely on the convenience of one of the state's largest banking networks. Trustmark has more locations in the places where you need us most. We have Trustmark Express ATMs throughout the state. And 130,000 ATMs around the world through our GulfNet and CIRRUS® affiliations. Plus, Trustmark's Express Check debit card gives you purchasing power wherever MasterCard® is accepted, letting you pay by check without writing one. So, next time you're worried about getting to the bank, relax. Whether you're headed ACROSS TOWN or ACROSS THE STATE, there's one bank you can trust to be there: TRUSTMARK.



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Looking Ahead

Candace E. Keller, M.D., M.P.H.
The President's Page

“We come together, not as a congratulatory assembly merely, but as guards on duty to signal the ills that afflict humanity and to counsel for their defeat.”

— Dr. N. L. Guice
1887 MSMA Presidential Address

I am deeply honored and humbled to serve as your President for the next twelve months. The Mississippi State Medical Association is a great organization because it is comprised of physicians with great compassion, unparalleled character, and unfailing vision. This truth has continued from the earliest days of our existence when a handful of six physicians first met in Jackson on December 15, 1856, until now as an organization of over 3,000 physician members. In those days of the late 1800's, MSMA was the guiding light in all matters regarding health which came before the state legislature. Legislation which first established the state licensing board and the State Board of Health were suggested and steered through the legislature by MSMA. It is up to each and every MSMA member to once again take up the mantle of leadership and be the driving force of healthcare related legislation. To be sure, the nature of politics today is a far cry from what it was back then. However, every Mississippi doctor can and should be a member of MSMA and our Mississippi Medical Political Action Committee. Every Mississippi physician can and should know his or her state and federal legislators and maintain contact with them on a regular basis. Now is the time for the MSMA sleeping giant to arise, its voice be heard, and its influence felt as never before. We can afford nothing less!

Illness and disease affecting Mississippians, as well as the weapons available to fight them, were certainly far different then than they are today. Nonetheless, we also have tremendous opportunities to improve the health of our patients here in Mississippi. Heart disease, diabetes, and cancer continue to plague us. Recent statistics indicate that only 37.2% of Mississippi adult women receive a mammogram at least once every two years. Only 51.5% of Mississippi Medicare diabetics received at least one hemoglobin A1c in a year's time. Only 46.3% of appropriate patients with atrial fibrillation were discharged on warfarin. We, as physicians, can and must make a difference in improving the health of our citizens.

In closing, I quote again from the 1887 address by MSMA President Guice:

“No, Fellows, we cannot, must not pause! We must go on! Science demands it; humanity demands it, the State expects it. Hope beckons to brighter and fairer meads of triumph.” So it is. Let us put aside division. Let us unite as we look to what lies ahead. Onward and upward!

Candace

THE EYES HAVE IT

The notation at the top of the chart read, "Possible eye infection". When I entered the exam room, the young mother reiterated her concern... "It's his eyes."

Cursory inspection of the fourteen month old's eyes indeed revealed moderate conjunctival injection. However, that redness paled as I was struck by the toddler's labored wheezing.

"Mama, how long has he been breathing like this?" When she volunteered, "Most of the week," I realized that we had a problem--in more ways than one! The obvious respiratory distress narrowed our options to hospitalization to which the mother readily agreed.

On evening rounds I found the child's clinical status dramatically improved after only a brief stay in the mist tent and a couple of nebulizer treatments. His look of wide-eyed wonder yet quiet contentment as he straddled his mother's lap and hugged her neck tightly belied his earlier plight.

Later that evening nursing personnel notified me of an unexpected turn of events. After searching high and low, neither patient nor mother was to be found in the hospital. Their room had been stripped of all personal belongings. Someone recalled having seen the child in his mother's arms earlier in the hallway, but there had certainly been no indication of an impending abduction.

This disturbing act of what I considered child abuse was referred to Social Services for reporting to the county welfare department.

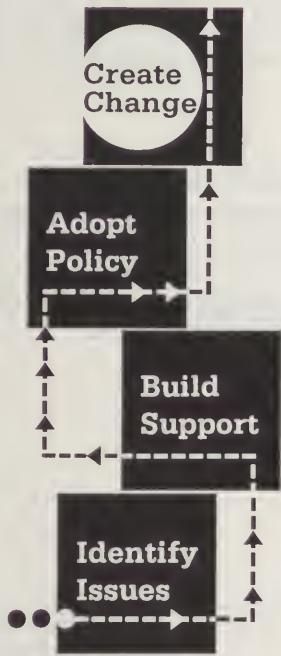
Oh, it was his eyes all right. The image still haunts me: Those big eyes reflecting childlike innocence, unconditional love, and total trust as they searched that mother's face.

*Stanley Hartness, M.D.
—Associate Editor*

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.

The American Medical Association Organized Medical Staff Section (AMA OMSS) invites your medical staff to be represented at its

2000 Annual Assembly Meeting June 8-12, in Chicago



The OMSS is a powerful voice, advocate, and resource for empowering hospital and other health care entity medical staffs. The OMSS meets twice year to:

- **Identify issues** of critical importance to medical staffs, such as on-call emergency coverage and EMTALA guidelines, scope of practice, "exclusive credentialing," HCFA regulations, and medical errors;
- **Build support** for these issues through educational programs, special issue forums, state and regional caucuses, reference committee hearings, the OMSS Assembly, and the AMA House of Delegates; and
- Persuade the AMA to **adopt policy** that will further the needs and concerns of medical staffs; so as to
- **Create change** at various levels within the public and private sector in an effort to improve the quality and delivery of medical care and the professional and personal success of physicians

Elect a member of your medical staff to serve as an OMSS representative* and attend the **2000 Annual AMA OMSS Assembly Meeting**. Topics for educational programs include:

- communication basics, team building and problem-solving
- on-call emergency coverage and EMTALA compliance
- scope of practice
- medical staff bylaws and the changing environment
- building "win-win" relationships between medical staffs and hospital/IDS administration
- status of legislative initiatives
- medical errors
- the impact of MCO insolvency on physician practice

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at omss@ama-assn.org

*Must be an AMA member

American Medical Association
Physicians dedicated to the health of America



I.Q.H., Information and Quality Healthcare

It was a warm muggy night at the Mississippi State Charity Hospital. A previous thunderstorm had interrupted electrical power to the lighting system for the hospital grounds. Nurse Smith, a recent graduate of the Mississippi Nursing School, was delivering medical supplies to the maximum security building. As she walked alone towards the entrance, she sensed something was wrong. Suddenly she turned and saw a large-figured man walking behind her. He spoke, and his words sent chills down her spine. She pondered whether to run or fight. The large figure loomed over her now and said, "Do physicians in the State of Mississippi need to improve the quality of care given to Medicare beneficiaries?"

Did I grab your attention? For the past six months, I.Q.H. has held regional meetings, has mailed information, has visited individual hospital medical staffs to deliver baseline rates of compliance to the simple quality indicator of our Medicare projects, and has had articles published in the MSMA journal describing our findings and project goals.

Recently, a noted physician claimed in his article on the "ABC's of AMI Treatment" that this is not rocket science. It is simply the "normal" standard of care that should be expected. How do you react when you hear someone say that the baseline rates for Mississippi always seem to be either in the lowest bracket or on the bottom of the list compared to other states that are in our contract cycle? Do you initially react by questioning the validity of the data? Do you feel that these findings really don't apply to you--it must be only related to your competitors in the next town? Do you immediately shout that you don't want anyone, especially the government, telling you how to practice medicine?

Since I know that almost all physicians in Mississippi strive to do the best they can do, my hope is that this information will be accepted as being educational and will be accepted as an opportunity to show the rest of the nation that we will respond to the "quality call" and show the greatest improvement in these simple, easy-to-do, quality projects.

If this article does not get your attention, what else should we do? To answer this question, or to seek further information, call us at 601-957-1575.

—James S. McIlwain, M.D., President, I.Q.H.

Health Care Quality Improvement Program (HCQIP)

The purpose of the Health Care Quality Improvement Program is to measure process-related indicators that are selected from clinical guidelines or other "evidence-based" studies and to work collaboratively with health care professionals to address opportunities for improvement. In the Sixth Scope of Work, emphasis is being placed on the following clinical areas to impact the Medicare population.

National Health Improvement Clinical Topics and Quality Indicators

CLINICAL TOPIC	QUALITY INDICATORS
Acute Myocardial Infarction	Early administration of aspirin Aspirin at discharge Early administration of Beta blockers Beta blockers at discharge ACE inhibitor for low LVEF Time to initial reperfusion Documentation of smoking cessation counseling provided during hospitalization
Heart Failure	Appropriate assessment and treatment for low LVEF
Pneumonia	Timing from hospital arrival to the initial antibiotic dose Antibiotic consistent with current recommendations Blood cultures collected before antibiotics administered Screened for <u>or</u> given influenza vaccination Screened for <u>or</u> given pneumococcal vaccination
Influenza/Pneumococcal Vaccine	Statewide influenza vaccination rate Statewide pneumococcal vaccination rate
Atrial Fibrillation	Warfarin for atrial fibrillation
Stroke/Transient Ischemic Attack	Aspirin/antiplatelet/warfarin for stroke and TIA Reduce inappropriate use of sublingual nifedipine
Diabetes	Annual retinal exam by eye professional HbA1c testing Annual testing of lipid profile
Breast Cancer	Annual screening mammography

New Members

AYINALA, S. R., Jackson. Born April 24, 1969 in India; MD S.V. Medical College, India, 1992; internal Medicine residency Brooklyn, New York 7/1/96 - 6/30/99; elected by Central Medical Society.

AZAR, DEBORAH T., Hattiesburg. Born Monroe, LA, September 22, 1965; MD Louisiana State University School of Medicine, Shreveport, LA, 1993; general surgery, Tulane University Medical Center, New Orleans, LA, 1994-95; urology residency, same, 1995-99; elected by South MS Medical Society

BARCLAY, VIVEK, Gulfport. Born Kerala India, January 27, 1960; MD Govt. Medical College, India, 1983; anesthesiology residency, University of South Alabama Medical Center, Mobile, AL, 1991-95; elected by Coast Counties Medical Society

BETCHER, RAYMOND E., Amory. Born 11/19/1964 in Wichita, KS; MD University of Mississippi School of Medicine, Jackson, MS, 1993; internship Univ. of Tenn. Health Sciences, Memphis, TN, one year; Ob-Gyn residency, Carillon Health System, Virginia, 1994-98; elected by Northeast Medical Society.

BOLING, GREGORY H., Jackson. Born Camp Lejune, NC, Nov. 26, 1963; MD University of Tennessee Medical School, Memphis, TN 1986; internship, one year, University of South Alabama, Mobile, AL; anesthesiology residency, Same, 1992-95; elected by Central Medical Society.

BRADLEY, GRETCHEN, Pearl. Born Tulsa, OK, March 3, 1970; MD University of Florida School of Medicine, Gainesville, FL, 1996; family practice internship, University of South Alabama Medical Center, Mobile, LA, 1996-97; elected by Central Medical Society.

BROWN, FRANK A., Belzoni. Born Yazoo City, MS, July 31, 1957; MD University of Wisconsin School of Medicine, Madison, WI, 1994; internal medicine residency, Wright State University Medical Center, Dayton, OH, 1994-87; elected by Delta Medical Society.

CLAPP, ROGER C., JR., Starkville. Born Montgomery, AL, October 11, 1964; MD University of Mississippi School of Medical, Jackson, MS, 1994; general surgery residency, East Tennessee State University and Quillen college of Medicine, Johnston City, TN 1994-99; elected by Prairie Medical Society.

BREWER, EDWARD A., JR., Richland. Born March 10, 1964, Leakesville, MS; MD University of Mississippi School of Medicine, Jackson, MS, 1991; family practice residency, Navy Hospital, Pensacola, FL, 1995-97; elected by Central Medical Society.

BRUNI, TIMOTHY G., Gulfport. Born August 25, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1996; interned University Medical Center, Jackson, MS, 1996; interned and pediatric residency, Same, 1996-99; elected by Coast Counties

Medical Society.

BYRAM, MELODY F., Sebastopol. Born Waukegan, IL, 12/6/1963; DO University of Osteopathic Medicine and Health Sciences College, Des Moines, Iowa, 1996; pediatric residency, University Medical Center, Jackson, MS, 1996-99; elected by East MS Medical Society.

CALCOTE, BRYAN S., Brookhaven. Born Jackson, MS, July 27, 1962; MD Louisiana State University School of Medicine, Shreveport, LA, 1993; internal medicine residency, University of Florida Medical Center, Gainesville, FL, 1996; elected by South Central Medical Society.

COLLOP, NANCY A., Jackson. Born Bradford, PA, December 21, 1958; MD Penn. State University School of Medicine, Hershey, PA, 1984; internal medicine residency, Medical College of VA, Richmond, VA, 1984-87; pulmonary/critical care, University of Florida Medical Center, Gainesville, FL 1987-90; elected by Central Medical Society.

CROOK, TAMMY L., Jackson. Born Decatur, GA, April 21, 1968; MD University of Alabama School of Medicine, Birmingham, AL, 1994; ob-gyn residency, Tulane University Medical Center, New Orleans, LA., 1994-95; internal medicine residency, University Medical Center, Jackson, MS, 1996-98; elected by Central Medical Society.

DILLARD, SHEILA DIANE, Hurley. Born Ozark, AL, July 7,

1961; MD University of South Alabama Medical School of Medicine, Mobile, AL, 1996; family practice, University of South Alabama Medical Center, Mobile, AL, 1996-991 elected by Coast Counties Medical Society.

DUDLEY, WILLIAM H., Natchez. Born November 4, 1957; MD, University of Mississippi School of Medicine, Jackson, MS, 1996; family medicine residency, University Medical Center, Jackson, MS, 1996-99; elected by Homochitto Medical Society.

EVANS, I. HARRISON, Tupelo. Born Charleston, SC, October 9, 1954; MD University of Mississippi School of Medicine, Jackson, MS, 1982; psychiatry residency, Wilford Hall USAF Medical Center, Lackland, TX, 1982-86; elected by Northeast MS Medical Society.

ERICKSON, ALAN R., Tupelo. Born Pierce, NE, May 25, 1962; MD University of Nebraska School of Medicine, Omaha, NE 1990; internal medicine residency, Fitzsimmons Army Medical Center, 1991-93; rheumatology fellowship, same, 1993-95; elected by Northeast Medical Society.

FAGAN, JOHN D., Vicksburg. Born Ottoman, OH, August 24, 1955; MD University of Texas School of Medicine, Galveston, TX, 1984; general surgery and urology residency, University of Texas Medical Center, Galveston, TX, 1984-90; elected by West MS Medical Society.

FAIN, GEORGE D., Ocean Springs. Born Biloxi, Nov. 19, 1950; MD University of Missis-

sippi School of Medicine, Jackson, 1980; pediatric residency, Keesler AFB, Biloxi, MS 1980-83; elected by Coast Counties Medical Society.

FLETCHER, REID, Jackson. Born Greenwood, MS, May, 6, 1965; MD University of Mississippi School of Medicine, Jackson, MS, 1991; anesthesiology internship & residency, Willford Hall Medical Center, San Antonio, TX, 1991-92 and 1994-97; elected by Central Medical Society.

FORD, TERRY D., Bay Springs. Born Laurel, MS, September 15, 1958; DO Southcrestown University, Ft. Lauderdale, FL, 1988; family practice residency, University of Alabama Medical Center, Birmingham, AL; elected by South MS Medical Society.

HAMMITT, GEORGE M., Tupelo. Born Vicksburg, MS, January 16, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; interned and anesthesiology residency, University Medical Center, Jackson, MS; elected by Northeast MS Medical Society.

HASHIMOTO, LUIS A., Jackson. Born Lima, Peru, January 27, 1953; MD San Marcos National University School of Medicine, Peru, 1979; 1981-84 Loayza Hospital, Lima, Peru; 1984-90, Tohoku University, Sendai City, Japan; general surgery residency, The Cleveland Clinic Foundation, Cleveland, OH, 1990-96; elected by Central Medical Society.

HAQUE, KALEEM UL, Lucedale. Born Pakistan, February 20, 1967; MD AGA Khan Univ., Karachi/Pakistan, 1990; interned,

MetroHealth St Luke's Medical Center, Cleveland, OH, 1992-93; internal medicine residency, University Hospitals of Cleveland, Cleveland, OH, 1993-95; Nephrology fellowship, University Hosp., Cleveland, OH, 1995-96 and Johns Hopkins Hospital, Baltimore, MD, 1996-98; elected by South MS Medical Society.

HERNANDEZ, CHARLES D., Hattiesburg. Born Jamaica , WI, March 17, 1959; DO Michigan State University, East Lansing, MI 1989; internal medical residency, Detroit Osteopathic Hospital Southfield, MI, 1990-93; elected by South MS Medical Society.

DARLING, BRYAN K., Tupelo. Born Topeka, KS, June 16, 1961; MD Medical College of GA, Augusta, GA, 1987; pediatric residency, Portsmouth Naval Hospital, Portsmouth, Maine, 1987-90; neonatal-perinatal medicine fellowship, USUHA, Bethesda, MD, 1990-93; elected by Northeast MS Medical Society.

HIGHTOWER, VERNORA D., West Point. Born Chicago, IL, November 17, 1967; MD Finch University of Health Sciences Chicago Medical, Chicago, IL, 1996; pediatric residency, Christ Hospital & Medical Center, Oaklawn, IL, 1996-99; elected by Northeast MS Medical Society.

HILL, DOUGLAS L., Columbus. Born Columbus, MS, November 6, 1960; MD Vanderbilt University School of Medicine, Nashville, TN, 1987; internship & residency, Duke University Medical Center, Durham, NC, 1987-90; cardiovascular diseases fellowship, University of Alabama Medical Center, Birmingham, AL, 1990-93; elected

by Prairie Medical Society.

HOLMES, KEVIN H., Columbia. Born Prentiss, MS, August 4, 1961; MD University of Mississippi School of Medicine, Jackson, MS, 1996; internal medicine residency, University of Mississippi Medical Center, Jackson, MS, 1996-99; elected by South MS Medical Society.

JAMAL, ALTAF A., Pascagoula. Born Pakistan, April 26, 1962; MD Sind Medical College, Pakistan, 1988; pediatric residency, University of South Alabama Medical Center, Mobile, AL, 1996-99; elected by Singing River Medical.

JARJOURA, CHADI M., Laurel. Born Beirut-Lebanon, 1967; MD St. Joseph University Faculty of Medicine, Beirut-Lebanon 1992; interned one year, Seton Hall University; ob-gyn residency, North Eastern Ohio Univ., St. Elizabeth Hospital, Youngstown, OH 1994-97; elected by South MS Medical Society.

JEFFREYS, KIRK R., Tupelo. Born Jackson, MS, August 29, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; internal medicine internship, University of MS Medical Center, Jackson, MS, 1995-96; ophthalmology residency, same, 1995-99; elected by Northeast MS Medical Society.

KENNEDY, RICHARD ELLIS, Jackson. Born Greenville, MS, December 15, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1994; transitional internship, Univ. of Arkansas Medical Center, Little Rock, AR, 1994-95; psychiatry residency, same 1995-98; psychiatry fellowship,

Medical College of Virginia, Richmond, VA, 1998-99; elected by Central Medical Society.

KIM, KEITH C., Ocean Springs. Born Korea, March 6, 1968; MD University of North Carolina at Chapel Hill College of Medicine, Chapel Hill, NC 1994; general surgery residency, Univ. of NC Medical Center, Chapel Hill, NC, 1994-99; elected by Singing River Medical Society.

KLIESCH, JOHN F., McComb. Born New Orleans, LA, March 6, 1968; MD University of Mississippi School of Medicine, Jackson, MS, 1996; family practice residency, University Medical Center, Jackson, MS, 1996-99; elected by South Central Medical Society.

LAM, CHARLES C., Pearl. Born January 4, 1956; MD Meharry School of Medicine, Nashville, TN, 1986; internal medical residency Meharry Medical Center, Nashville, TN, 1991-94; elected by Central Medical Society.

LANCON, JOHN A., Jackson. Born Morgan City, LA, September 4, 1964; MD Louisiana State University School of Medicine, Shreveport, LA, 1990; interned one year, same; neurosurgery residency, Univ. of Mississippi Medical Center, Jackson, MS, 1992-98; pediatric neurosurgery fellowship, University of Texas Southwestern Medical center, 1998-99; elected by Central Medical Society.

LAWIN, PENNY J., Jackson. Born Hastings, MN, October 16, 1964; MD Rush-Pres. St. Luke's Medical School, Chicago, IL, 1993; orthopaedic surgery residency, same 1994-97; foot & ankle surgery fellowship, Duke Univer-

sity School of Medicine, 1/99 - 7/99; elected by Central Medical Society.

LOVE, ROBERT T., III, Greenville. Born Little Rock, AR, January 14, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1990; general surgery residency, Tulane University Medical School, New Orleans, LA, 1990-96; plastic surgery residency, University of So. California, Los Angles, CA 1996-98; elected by Delta Medical Society.

MADNANI, HARISH M., Tylertown. Born Poona, India, September 11, 1915; MD SMS Medical College, Jaipur India; internship general surgery Flushing Hospital, Flushing, NY, 1980-81; internal medicine residency St. Barnabas Medical Center, Livingston, NJ, 1981-84; elected by South Central Medical Society

McGAUGH, RONALD C., Meridian. Born Memphis, TN, Sept. 17, 1963; MD University of Arkansas School of Medicine, Little Rock, AR, 1986-92; interned one year family practice, same, 1992-93; family medicine residency, University of Mississippi Medical Center, Jackson, MS, 1997-99; elected by East MS Medical Society.

McNAIR, ROBBYE D., Greenwood. Born Rolling Fork, MS, Sept. 27, 1968; MD Johns Hopkins School of Medicine, Baltimore, MD, 1995; ob-gyn residency Northwestern University Medical Center, Chicago, IL, 1996-99; elected by Delta Medical Society.

MLEV, TZONKO V., Tupelo. Born Karlovo, Bulgaria, April 23, 1964; MD University of Medicine,

Plovdiv, Bulgaria, 1986; internal medicine/pediatrics residences, Long Island College Hospital, Brooklyn, NY, 1994-1997; nephrology fellowship, Brown University School of Medicine, Providence, RI, 1997-99; elected by Northeast MS Medical Society.

MOORE, TOMAS C., Vicksburg. Born Waco, TX, August 28, 1950; MD Southwestern Medical School of Medicine, Dallas, TX, 1975; pediatric residency, University of South Florida Medical Center, Tampa, FL, 1975078; elected by West MS Medical Society.

NORTON, THOMAS C., Natchez. Born Oxford, MS, February 6, 1969; MD University of Mississippi School of Medicine, Jackson, MS, 1995; ophthalmology residency, Texas Tech University, Lubbock, TX, 1996-99; elected by Homochitto Valley Medical Society.

O'MARA, JAMES W., JR., Jackson. Born Jackson, MS, May 21, 1967; MD Vanderbilt University School of Medicine, Nashville, TN, 1993; interned one year general surgery and orthopaedic surgery residency, Georgetown Univ. Medical Center, Washington, DC, 1993-98; sports medicine fellowship, American Sports Medicine Institute, Birmingham, AL, 1998-99; elected by Central Medical Society.

PACE, JAMES MICHAEL, Eupora. Born Hattiesburg, MS, February 19, 1963; MD University of Mississippi School of Medicine, Jackson, MS, 1996; family practice residency, University of Mississippi Medical School, 1997-99; elected by North Central Medical Society.

PACE, SIDNEY K., Pascagoula. Born Poplarville, MS, January 8, 1964; MD University of Mississippi School of Medicine, Jackson, MS, 1992; internal medicine residency, University of South Alabama Medical Center, Mobile, AL, 1992-95; elected by Singing River Medical Society.

PATEL, DIPAK B., Meridian. Born India, February 27, 1971; MD N. H. L. Municipal Medical College, India 1994; family practice residency, LSU Medical Center, Monroe, LA, 1996-99; elected by East MS Medical Society.

PURVIS, JANI L., Brookhaven. Born Slidell, LA, July 25, 1967; MD University of Mississippi School of Medicine, Jackson, MS, 1993; pediatric internship, same, 1993-94; diagnostic radiology, Louisiana State University Medical Center, New Orleans, LA, 1993-94; elected by South Central Medical Society.

RAYBON, KELVIN B., McComb. Born Pascagoula, MS, May 10, 1963; MD Tulane University School of Medicine, New Orleans, LA, 1989; internal medicine residency, Keesler Medical Center, Biloxi, MS, 1989-92; hematology & medical oncology fellowship, Wilford Hall Medical Center, San Antonio, TX, 1996-99; elected by South Central Medical Society.

ROSENFIELD, DAVID J., Laurel. Born Suffolk, MA, November 21, 1965; MD University of Wisconsin Medical School, Madison, WI, 1994; anesthesiology residency, Ochsner Medical Foundation, New Orleans, LA, 1995-99; elected by South MS Medical Society.

SIGREST, TED D., Hattiesburg. Born Jackson, MS, November 28, 1951; MD University of Mississippi School of Medicine, Jackson, MS, 1991; pediatric residency, University of Mississippi Medical Center, Jackson, MS, 1991-94; elected by South MS Medical Society.

SIKES, JAMES N., Brookhaven. Born Mobile, AL, February 20, 1966; MD University of Alabama Medical School, Birmingham, AL, 1993; orthopaedic surgery residency, University of Mississippi Medical Center, Jackson, MS, 1993-98; elected by South Central Medical Society.

SLIFE, DAVID M., Meridian. Born Baltimore, MD, March 7, 1951; DO Kirksville College of Osteopathic Medicine, Kirksville, MO, 1983; internal medicine & cardiology residency, Brooke Army Medical Center, Ft. Sam Houston, TX 1983-88; elected by East MS Medical Society.

SLIGH, THOMAS K., Vicksburg. Born Natchez, MS, April 20, 1970; MD University of Mississippi School of Medicine, Jackson, MS, 1996; internal medicine residency, Emory University Medical Center, Atlanta, GA, 1996-99; elected by West MS Medical Society.

SNYDER, JAMES A., Meridian. Born Amarillo, TX, May 30, 1956; DO University of Health Sciences College of Osteopathic Medicine, Kansas City, MO 1986; interned one year, same; elected by East MS Medical Society.

SORIANO, MARIA C., Heidelberg. Born Manila, Philippines, April 30, 1962; MD University of the Philippines, Manila,

Philippians, 1987; pediatric residency, Long Island College Hosp., Long Island, NY, 1994; pediatric ER, Same, 1994-95; elected by South MS Medical Society.

SORIANO, MARIA R., Laurel. Born Manila Philippines, October 8, 1964; MD University of Santo Tomas, Manila, Philippines, 1990; pediatric residency Long Island College Hospital, Brooklyn, NY, 1996; elected by South MS Medical Society.

SUMMERS, EVAN L., Ocean Springs. Born Kirksville, MO, August 3, 1964; DO, College of Osteopatahic Medicine of the Pacific, Pomona, CA 1995; internal medicine residency, Alameda County Medical Center, Oakland, CA 1995-98; elected by Singing River Medical Society.

SWAYZE, ALAN R., McComb. Born Jackson, MS, April 2, 1967; MD University of Mississippi School of Medicine, Jackson, MS 1993; orthopaedic surgery residency, Same, 1993-98; elected by South Central Medical Society.

TAN, MICHAEL D., Meridian. Born Manila Philippines, September 5, 1968; DO Western University of Health Sciences College of Osteopathic Medicine of the Pacific, Pomona, CA 1995; internal medicine & neurology residency Kaiser Foundation Hospital, Los Angeles, CA, 1995-99; elected by East MS Medical Society.

TASSIN, GERALD B., Tupelo. Born New Orleans, LA, April 28, 1960; MD Louisiana State University School of Medicine, New Orleans, LA, 1995; internal medicine residency, Ochsner Medical Foundation, New Orleans, LA, one

year; diagnostic radiology university of Texas Health Science Center, Houston, TX, 1986-90; vascular & interventional radiology fellowship, 1990-91, M.D. Anderson Cancer Center, Houston TX, 1990-91; elected by Northeast Medical Society.

THOMAS, DAISY M., Belzoni. Born Amite Co., August 7, 1950; MD Case Western Reserve School of Medicine, Cleveland, OH, 1972-76; family practice residency, University of MS Medical Society, 1976-79; elected by North Central Medical Society.

TIBBS, BOB C., Cleveland. Born Jackson, MS, January 22, 1964; MD, University of Mississippi School of Medicine, Jackson, MS, 1992; pediatric residency, University of Mississippi Medical Center, Jackson, MS, 1992-95; elected by Delta Medical Society.

TIBBS, PATRICIA A., Laurel. Born Hungary, October 10, 1965; MD Makereke Medical School, Uganda, 1990; pediatric residency, University of Illinois Medical Center, Chicago, IL, 1993-95; pediatric fellowship, same, 1995-97; elected by South MS Medical Society.

TYRRELL, MARY C., Biloxi. Born Traverse City, MI, October 15, 1962; MD University of Texas School of Medicine, San Antonio, TX, 1989; diagnostic radiology residency, University of South Alabama Medical Center, Mobile, AL, 1990-94; elected by Coast Counties Medical Society.

VERGUNST, KRISTIN J., Pascagoula. Born Ellenville, NY, January 16, 1954; MD Albert Einstein College of Medicine,

Bronx, NY 1990; internal medicine residency, USAF Medical Center, Wright-Patterson AFB, OH, 1990-93; nephrology fellowship, Wilford Hall Medical Center, Lackland AFB, TX 1993-95; elected by Singing River Medical Society.

WEBB, D. ERIC, Tupelo. Born Lakeland, FL, July 24, 1966; MD University of Alabama School of Medicine, Birmingham, AL, 1993; ob-gyn residency University Medical Center, Jackson, MS, 1993-97; elected by Northeast MS Medical Society.

WEIERMAN, ROBERT J., Gulfport. Born Neptune, NJ, July 31, 1942; MD Georgetown University Medical School, Washington, DC, 1968; general surgery internship, Jersey Shore Medical Center, NJ; general surgery residency, same, 1969-70; orthopaedic surgery residency, College of Medicine & Dentistry Medical Center, Newark, NJ 1970-72; elected by Coast Counties Medical Society.

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Published weekly during each annual session of the Mississippi Legislature, this informative newsletter provides association members with the latest news on legislative and political events. It also keeps members abreast of health legislation that is under consideration and the association's position on hundreds of health-related bills.

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long medical issues forum where CME credit is available for attendees. Dates for upcoming meetings on the Mississippi Gulf Coast are as follows: May 4-6, 2001; May 3-5, 2002; May 16-18, 2003 and June 4-6, 2004.

**MSMA Website 601-853-6733
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The association's website at www.msmaonline.com provides a multitude of information and services for MSMA members and the general public. A special "members only" page provides specialized services, including links to other health-related and physician sites.

OPPORTUNITIES FOR INVOLVEMENT

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Female members of the association meet periodically to discuss their mutual concerns and work on a number of initiatives that target women. Members of the caucus also hold an annual breakfast meeting with female members of the Mississippi Legislature.

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MSMA members under age 40 or who have been in practice less than five years can participate with their colleagues in addressing some of the unique problems affecting physicians as they begin practice.

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The Status of Primary Care in Rural Mississippi

**Susan Hart-Hester, Ph.D.
D. Melessa Phillips, M.D.**

As the nation focuses on an "overproduction" of primary care generalists, Mississippi continues to suffer from a severe shortage of health care providers. Despite evidence showing that a high percentage of graduates from the University of Mississippi School of Medicine, (Mississippi's only medical school) remain in-state and practice in primary care fields, issues highlighted by a Council on Graduate Medical Education (COGME) report continue to weigh heavily on the success of the health care delivery system in the state.¹ The Council on Graduate Medical Education's 1992 report suggests three continuing major national health care crises: 1) inadequate access to health care, 2) poor and/or unequal health care status within the population, and 3) the high cost of health care. These issues strike at the heart of the current health care delivery crisis in Mississippi.

According to a report funded by the Pew Charitable Trust, concerns about access to health care and cost efficiency in the market place will dramatically change the focus of the health-care system. Pew recommended that the nation's medical schools decrease their enrollment number of medical students from 100 to 75.² Yet, according to a report published by the American Academy of Family Physicians (AAFP), the current demand and trends in medical education will cause a continued shortage of family practitioners for at least the next 15 years.³ With or without reductions, the apparent problem in Mississippi is not one of production. Rather, the issue is one of maldistribution.⁴ Indeed, the maldistribution of family practitioners in both rural and underserved urban areas is a nationally recognized problem.⁵

Nearly 4,000 physicians have graduated from the University of Mississippi Medical School's four year medical education program since 1957. The majority of physicians (nearly 70%) stay in the state to practice medicine.⁶ Remarkably, over 50% of the graduates enter primary care fields i.e., general practice, general pediatrics, family physicians, general internists, and obstetrics and gynecology. A recent study by Forbes and colleagues (2000) surveyed 753 graduates of UMMC's 4 primary care residency programs (1). Results of the study reinforce the knowledge that graduates are continuing to practice (98%), as well as maintain primary care as their principle area of emphasis. These numbers should paint a bright picture for the future of health care for Mississippians. However, the picture is cloudy.

A review of the number of active primary care physicians by county indicates that a large number of physicians practice exclusively in urban areas (See Map #1.) Indeed, nearly 53% of the primary care physicians licensed in Mississippi practice in only eight counties. If the present number of generalist physicians continue to practice in urban areas, then the issue of access to medical care for rural areas requires immediate attention.

The purpose of this paper is threefold: 1) to review the distribution of primary care physicians in Mississippi counties, 2) to assess future needs of primary care physicians in selected counties, and 3) to provide recommendations for recruitment and placement of primary care physicians in rural areas. Data for this report were derived from UMMC departmental records, UMMC

Educational Program Data, UMMC Alumni Association files, the State Board of Health, and the Board of Medical Licensure.

Mississippi is the fourth most rural state in the nation. Forty-nine of its 82 counties have fewer than 25,000 people and only eight cities have populations greater than 25,000. Fifty-one counties have population densities of less than 50 people per square mile. According to the 1990 Census, Mississippi's population is 2,573,216. As of July, 1995 nine counties classified as Standard Metropolitan Statistical Areas (SMSAs) had 59% of all active physicians (M.D. and D.O.) (Note: This includes DeSoto County). What does this mean for rural communities? As the 1999 data on Map #1 show, 41 counties have 10 or fewer primary care physicians providing health care services. Of that number, 17 counties have 5 or less primary care physicians actively providing health care services to residents. These figures are in sharp contrast to Healthy People 2010 objectives which target access to a primary care provider for at least 88 percent of the country's population.⁷

When primary care specialty is considered, rural counties are served predominately by family and general practitioners. This statistic is not surprising as national data indicate that 62% of patient office visits are to primary care physicians, with 41% to family physicians and general internists.⁸ In counties with less than 25,000 population, family and general practitioners comprise an estimated 85% of the primary care physicians in Mississippi. Map #2 shows data from each county by family practice specialty and other primary care specialties. Family practice physicians comprise the majority of active physicians in 45 counties and internal medicine physicians hold the majority of positions in 19 counties (1999 data). However, a closer review of the number of active primary care medical doctors by county indicates an alarming gap between the number of practitioners by area of specialty. As the data on Table 1 show, a large number of Mississippi counties do not have obstetricians (47 counties) or general pediatricians (35 counties). Six counties do not have active family medicine practitioners. An additional thirty-seven counties have 5 or fewer family practitioners.

A limited number (n = 205) of osteopathic physicians provide care to rural citizens. Eighty-eight are family practice physicians, with an additional thirteen licensed as general practice physicians. Again, the numbers indicate a maldistribution of physicians across the state. While fifty of the state's counties have osteopathic physicians, the larger counties comprising the SMSAs house an estimated 41% of the osteopathic practitioners – a similar picture as the primary care physicians. Moreover, Harrison, Hinds, Jackson, and Lauderdale counties have 35% (31) of the licensed osteopathic family physicians.

Maps 1 and 2 show the emphasis of primary care physicians across the state and are a significant comment to the importance of the residency training programs offered by the University Medical Center. Yet, these statistics highlight the need for recruitment and retention of physicians *from and in rural communities*. Such recruitment increases the likelihood that graduates will return to practice in rural areas.⁹

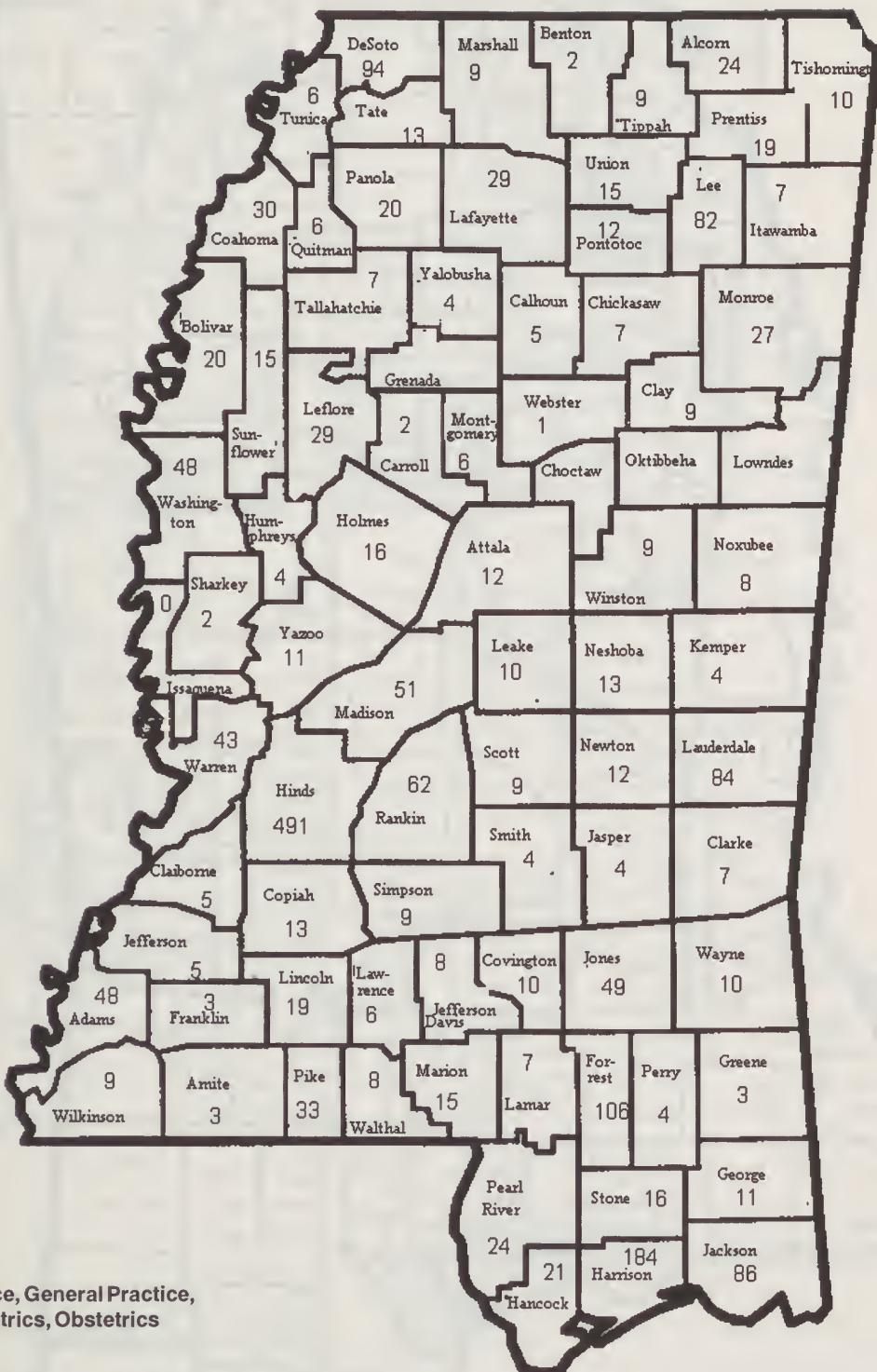
As Forbes' study documented, nearly 70% of the UMMC primary care residency graduates remain in the state to practice.¹ Of the 282 UMMC Family Residency graduates (1976-1999), 225 (80%) practice in Mississippi. Forty percent (n=91) practice in communities with populations less than 15,000. Additionally, thirty-seven graduates (16%) practice in communities with populations of 15,000 to 25,000. Fifty (50) of the graduates (22%) continue to serve as family medicine preceptors for medical students during clerkship and preceptorship rotations.

In addition, national statistics attest to the numbers of generalist physicians produced by family practice residency programs with 91% of the graduates practicing as family physicians.¹⁰ Again, these figures should prove encouraging as residency programs are clearly providing the nation's health delivery system with needed family practitioners. However, the numbers misrepresent the overall picture of application for this growing workforce. In Mississippi, figures on Maps 1 and 2 indicate the need for movement among this physician population to rural, less populated areas of the state. Who is serving the rural

Table 1: Counties with No Primary Care Physicians (By Specialty)

Specialty	Number of Counties without Active Physicians
Family Medicine	6
General Practice	28
Internal Medicine	15
Ob/Gyn	47
Pediatrics (General)	35

Map 1.— Active Primary Care Medical Doctors by County FY1999.

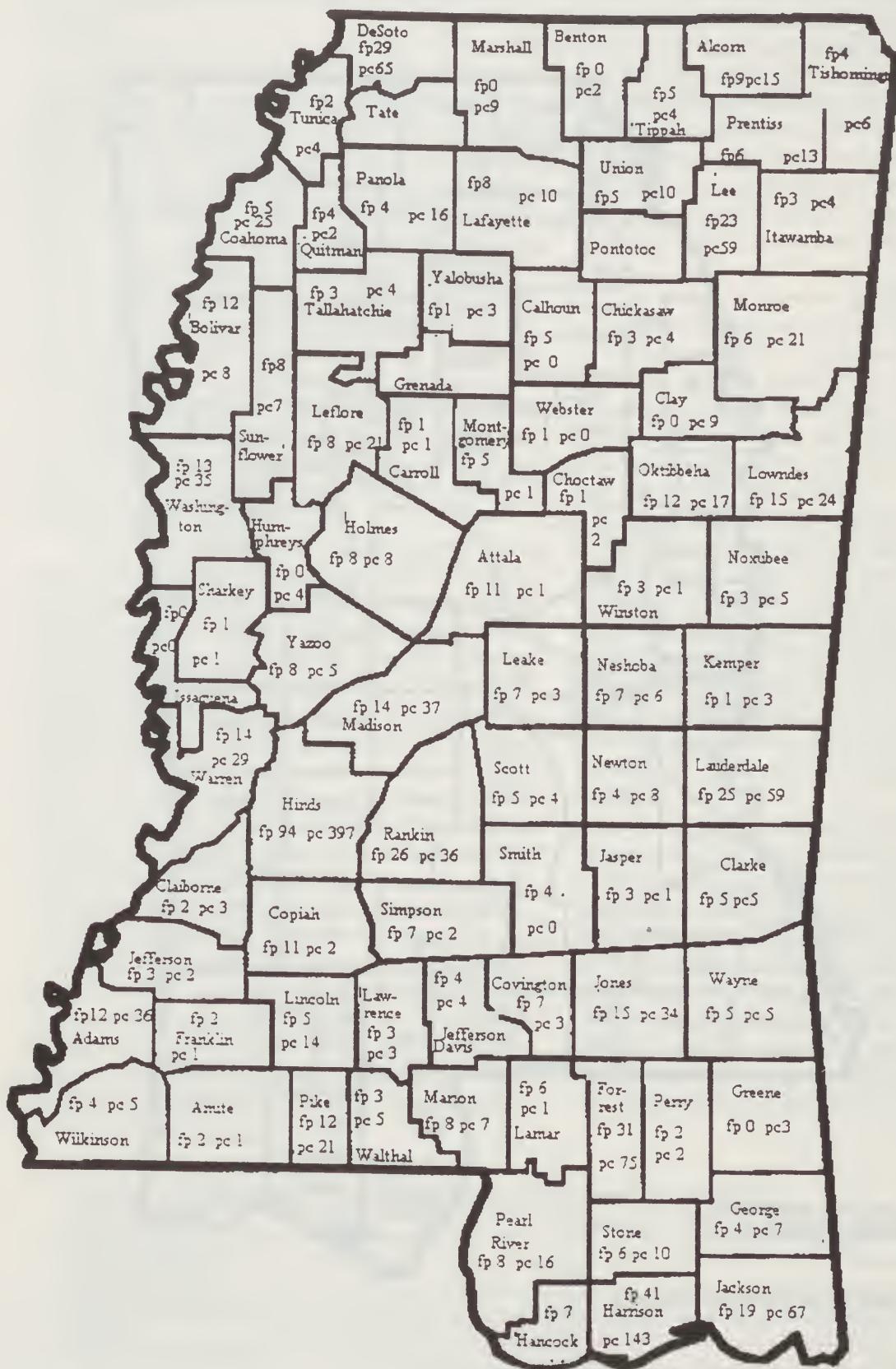


Includes: Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics and gynecology

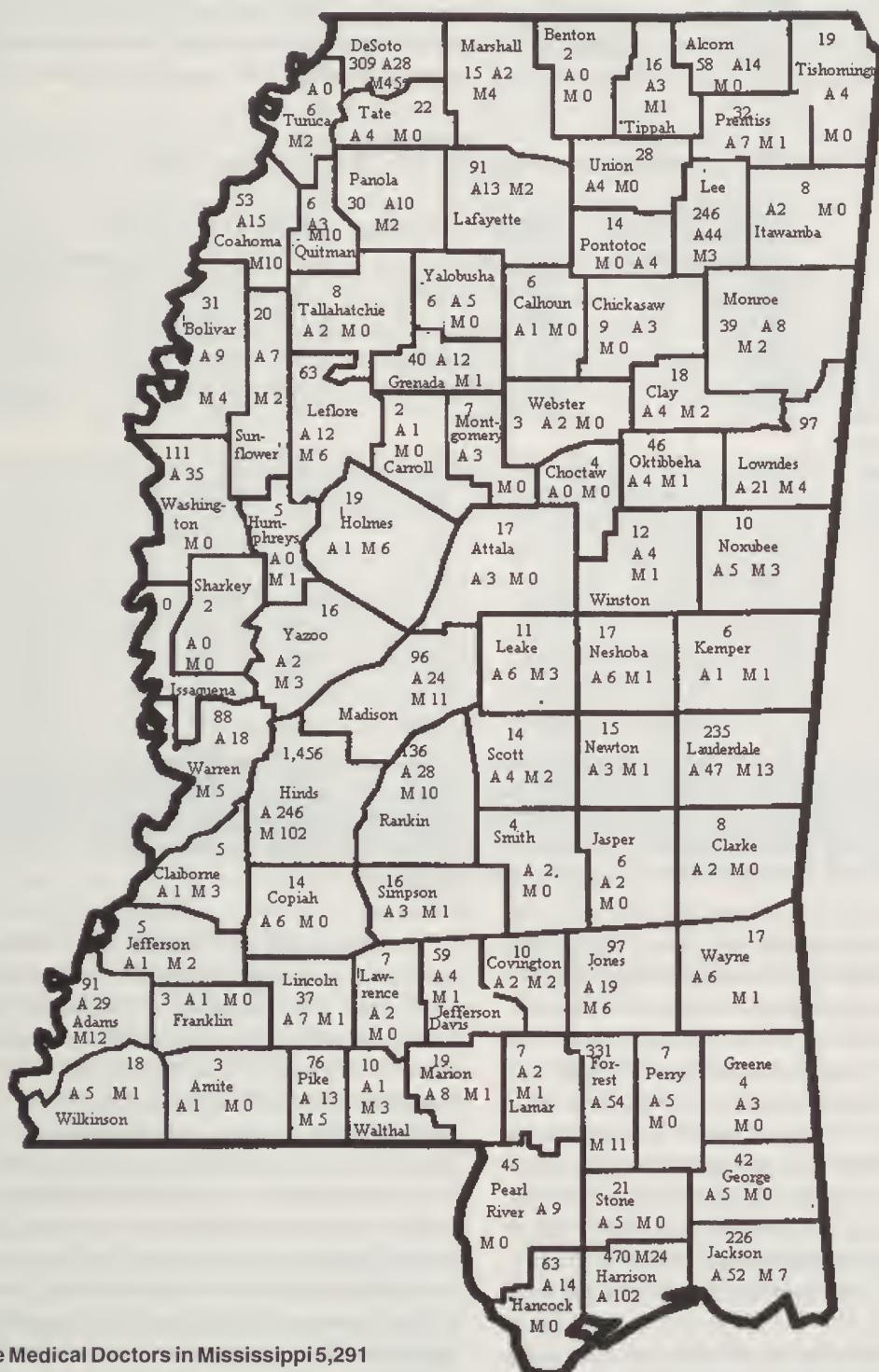
Source: Mississippi State Board of Medical Licensure

Map 2. — FP= Family Practice (698)

PC= General Practice (168) = Internal Medicine (718) = OB/Gyn (303) = Pediatrics (347)= 1,536



Map 3.— Number of Physicians: 60 years and older ; (1,053) (A)
 Number of African-American Physicians (318) (M)



population? A closer look at the numbers reveals the impact of an aging physician population on the delivery of health care to rural areas.

As shown on Table 2, of the 698 family physicians active in Mississippi, 171 (24%) are sixty years of age or older. Of the total number of *active primary care* physicians in Mississippi (2,234), 451 (20%) are at or near retirement age.

Many of these counties could lose nearly all of their active physicians within the next five to ten years. It is notable that with the exception of Lamar County, all of the counties have populations less than 20,000. None of the counties cited have more than 11 active physicians providing services to patients. Recruitment of physicians to rural areas is a vital issue to be addressed.

Table 2: Active Medical Doctors in Mississippi By Sex, Race, & Age (1999)

		Family Practice	General Practice	Internal Medicine	Ob/Gyn	Peds	Other	Not Known	TOTAL
TOTAL		698	168	718	303	347	3,012	545	5,291
SEX	Male	593	149	586	254	200	2,600	40	4,482
	Female	105	19	132	49	147	352	5	809
RACE	Caucasian	609	146	497	268	263	2,722	37	4,542
	African-American	65	14	81	27	33	97	1	318
	Indian	1	1	0	0	0	2	0	4
	Asian	22	7	107	7	45	153	7	348
	Other	1	0	33	1	6	38	0	79
AGE	<30	16	3	36	14	14	74	1	158
	30-34	72	9	144	38	66	312	3	644
	35-39	101	2	145	37	58	500	4	847
	40-44	113	12	131	51	58	458	1	824
	45-49	104	22	95	38	41	459	0	759
	50-54	74	16	56	30	36	370	2	584
	55-59	47	16	26	37	25	266	0	417
	60-64	44	17	24	20	20	224	1	350
	65-69	47	21	26	17	12	163	5	291
	> 70	80	50	35	21	17	186	28	417

Data Source: MS State Board of Medical Licensure (1999) (11)

While such numbers may not immediately signal trouble, recognition of the effect of impending retirement among physicians in rural areas needs further analysis. Map #3 shows the overall number of physicians in each county along with the number reaching retirement age. Nearly all counties have physicians who are sixty years or older; however, 10 counties are notable in that the majority of their physician population is nearing retirement age. For example, in Yalobusha County, five of the county's six licensed physicians are sixty years of age or older. *Note: These data represent all physician specialties – figures were unavailable by specialty for each county.*¹¹

Table 3 shows the total number of physicians along side the number of physicians sixty years of age or older by selected counties. These counties are highlighted as the impending retirement of physicians will reduce their numbers by at least half.

Recruitment efforts should first look at the characteristics of rural practitioners in order to access accurately what will bring, and more importantly keep, young primary care physician in rural areas. Amundson and Muss (1995) queried rural physicians in North Dakota regarding factors that significantly affected their decisions to remain in the rural community and continue practicing or to leave their current practice.¹² Findings suggested that the majority of the respondents were from small communities (65.8%) of less than 25,000. These authors found that a majority of the physicians' spouses were raised in small communities, a factor often overlooked by recruiters. Factors that contributed to the likelihood that a physician would leave his/her practice within the next five years included a lack of access to: 1) consultants, 2) continuing educational opportunities, and 3) general cultural activities. Additionally, physicians who indicated a lack of satisfaction in the doctor-patient

Table 3: Selected Counties - Physicians Sixty Years of Age or Older

County	Number of Physicians	Sixty Years or Older	County Population	Physician to Population Ratio After Retirement
Amite	3	1	13,328	1:6,664
Carroll	2	1	9,237	1:9,237
Franklin	3	1	8,377	1:4,188
Greene	4	3	10,220	1:10,220
Jefferson	5	1	8,653	1:2,163
Jefferson Davis	9	4	14,051	1:2,810
Lamar	7	2	30,424	1:6,085
Lawrence	7	2	12,458	1:2,492
Leake	11	6	18,436	1:3,687
Noxubee	10	5	12,604	1:2,521
Perry	7	5	10,865	1:5,432
Quitman	6	3	10,490	1:3,497
Smith	4	2	14,798	1:7,399
Yalobusha	6	5	12,033	1:12,033

relationship and their ability to treat different health care needs were also prime candidates for leaving their practice within the next five years.

Costa's (1996) study of PGY-3 residents' choices of practice sites substantiates these findings. Eighty-five percent of those responding gave top priority to the importance of the "significant other's wishes" in deciding where to practice.¹³ The perceived friendliness of the medical community and closeness to family and friends, as well as the importance of the significant other's job all ranked within the top five factors.

Rural communities can start the recruitment process early by negotiating with medical schools for placement of residents for rural rotations and by encouraging physicians already in practice to serve as preceptors for predoctoral level medical students. Communities may also offer incentives for residents to come to their towns, such as signing bonuses, loan repayments, guaranteed salaries, income subsidies, and start-up assistance. Costa's findings show that the majority of residents want to practice in a group setting; therefore, smaller communities may need to join forces to offer a larger population base and thus a greater financial incentive for physicians.

Admissions committees for medical training schools need to recognize the importance of accepting students with ties to rural communities. Predoctoral training programs should join together with rural communities to include opportunities for medical students to participate in rural preceptorships and clerkships, as well as continued rural preceptorships for residents. Clearly, research shows the positive effects that such early and continued exposure has on the likelihood that physicians will establish practices in rural areas.

Statistics prepared by the Bureau of Health Professions (1996) indicate that over one million Mississippians (47%) do not have access to a primary care provider.¹⁴ If Mississippi's sole medical school produces physicians consistent with the needs of the state, then the future for health care both rural and urban is bright. Yet, production of physicians by mere numbers will not resolve the issue of distribution of physicians across the state. Rural communities must link with their larger metropolitan counterparts and develop partnerships with the medical school to establish networks for consultative services and continuing education credits. Cooperative consortiums such as a rural research network could provide such contact for rural physicians in addition to serving as a technological guidepost for training and educating future health care providers.

As shown, residents from UMMC's Department of Family Medicine's residency program choose rural practice sites. These choices are due to the department's placement of students in rural communities early in the medical students' training through preceptorships and rural rotations. Contact is also maintained through an annual Physician Opportunity Fair on the UMMC campus which offers students, residents, and communities an opportunity to meet.

Data from the national Medical Expenditure Panel Survey (MEPS) indicates that 62% of Americans identify family physicians as their source of health care.¹⁵ We must continue to develop methods that address the recruitment and retention of residents into primary care and implement partnerships with rural communities that enable them to recruit and subsequently retain young primary care physicians.

As the state's only medical school, the UMMC must augment its production of physicians with the need to address issues of geographic maldistribution shown throughout this report. The curricular component of medical students' training needs multiple opportunities throughout all years of training for observing and practicing in rural settings. Such exposure will indeed have a positive impact on the future number of physicians locating in rural areas. As a teaching facility, the University Medical Center provides a strong link for rural communities as a consultative and referral service, as well as a site for continuing education. With links to the university community, the rural physicians need not practice in isolation. Graduates of the Department of Family Medicine provide strong evidence to the sustainability of such cooperative links from departmental and university level to the rural community.

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Susan Hart-Hester, Ph.D., is an Associate Professor and **D. Melessa Phillips, M.D.**, is Professor and Chairman of the Department of Family Medicine at the University of Mississippi Medical Center.

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M A X I M I Z I N G A D V A N T A G E S .
M I N I M I Z I N G R I S K S .

The Development of a Stroke Clinical Pathway: An Experience in a Medium-Sized Community Hospital

A. S. Wee, MD¹

W. B. Cooper, ART²

R. K. Chatham, ART²

A. B. Cobb, MD, MPH³

T. Murphy, RRA, CCS³

Abstract

Patients with acute ischemic strokes were studied in a medium-sized community hospital in Mississippi. Studies were done before and after implementation of the stroke clinical care pathway with emphasis on the following clinical indicators: 1) performance of a brain CT scan, 2) the search for the etiology of the stroke, 3) whether the patient was treated emergently for hypertension, 4) the use of measures to prevent deep-vein thrombosis, and 5) prophylactic drug treatment against recurrent stroke after hospital discharge. Following application of the clinical pathway, there was a significant improvement in all the clinical indicators that were felt to require further attention and none had a setback. The length of hospital stay was decreased, and there was no significant increase in the hospital costs in the post-pathway study despite an increase in the number of diagnostic and therapeutic procedures performed. When applied properly, clinical pathways can effectively mobilize hospital resources, maximize quality of care, and at the same time minimize costs.

Key Words: Ischemic stroke;
cerebrovascular disease;
clinical pathway;
critical pathway.

Introduction

Stroke or cerebrovascular disease is one of the leading causes of morbidity and mortality in the United States. It is estimated that in Mississippi, approximately 5,000 new cases of stroke occur every year¹. Mississippi is one of several states in the Southeastern United States

that are designated as the Stroke Belt. This is a region in which the incidence of stroke is relatively higher when compared to the nation-wide incidence. In the period between 1991 and 1995, the stroke mortality rate for Mississippi was 34.4 per 100,000 population. This is higher than the national stroke mortality rate of 26.5 per 100,000 population in the same time period¹.

Thus, in any hospital setting in Mississippi, one encounters patients presenting with stroke with great regularity. The following reports the experience of one community hospital in Mississippi in dealing with the clinical care and management of acute stroke.

Materials and Methods

Jeff Anderson Regional Medical Center (JARMC) is one of three medium-sized hospitals (180-260 beds) located in Meridian, a city with a population of 41,000 in Lauderdale County, Mississippi. In addition to providing medical care to the city residents, the three community hospitals have an additional drawing patient population of approximately 150,000 from the adjacent regions. JARMC was one of five hospitals in Mississippi that participated in the Stroke Management Quality Improvement Project sponsored by the Information and Quality Healthcare (formerly the Mississippi Foundation for Medical Care). Part of the data presented here came from that study. Some of the results in this study were also presented before the Joint Commission on Accreditation of Healthcare Organizations on February 10, 1997, in Meridian.

Between January 1, 1994, and December 31, 1994, the medical records of all Medicare recipients and beneficiaries with a discharge diagnosis of stroke were reviewed. Only occlusive cerebrovascular diseases (cerebral infarcts) were included in the study. Primary intracerebral hemorrhages and subarachnoid hemorrhages were excluded. Included were ischemic strokes from large-vessel or small-vessel occlusions appearing in any arterial vascular territory. The vascular occlusions were from either a thrombo-embolic origin (cardiac or arterial source) or an atherosclerotic disease process. There were 73 patients that fulfilled the above inclusion criteria. Two patients expired after 24 hours in the hospital. The medical records were examined with regards to the following five clinical indicators: 1) the performance of a brain CT scan and the timing of the procedure, 2) whether the patient received any emergent treatment for hypertension, 3) the search for an etiology of the cerebral infarct, 4) preventive measures against deep-vein thrombosis, and 5) preventive drug therapy for stroke at the time of patient discharge from the hospital.

After the above study was completed, the results were reviewed. A stroke clinical pathway was then implemented emphasizing the above-mentioned five clinical indicators in addition to other routine diagnostic and therapeutic procedures. It also included plans for discharge and rehabilitation of the patient. A clinical pathway is a written record outlining and documenting a plan for the hospital management and treatment of a medical problem, in this case, an acute stroke. Documents were provided to the physician, nurses, and other support staffs (dietary, social work, speech, occupational, and physical therapy) outlining the day-to-day patient care plan. A lay version of the stroke clinical pathway was also made available to the patient and family members, explaining in details the management of the acute stroke. The plans for initiating a stroke clinical pathway were conceived by the Performance Improvement Department of JARMC in September 1994. A Stroke Clinical Pathway Team was organized to draft the contents of the documents. Final forms of the documents were submitted to the Medical Care Committee and Medical Staff for approval.

The stroke clinical pathway was approved and implemented on January 1, 1995. A follow-up study was done between June 1, 1996, and May 31, 1997. Again, all medical records of Medicare beneficiaries with the discharge diagnosis of stroke were reviewed. The inclusion criteria were the same as in the baseline stroke study. There were 67 patients that fulfilled the above criteria. There were two mortalities. The findings in the baseline

stroke study, with reference to the five clinical indicators, were compared to the results in the follow-up study. Statistical analyses were performed to determine if the changes or variances observed in the different clinical indicators were significant. A p-value of 0.05 or less was considered statistically significant.

Results

In the baseline study, almost all of the patients had a brain CT scan as part of the evaluation of stroke (Table 1) and among those who had a CT scan, 76% were performed within 24 hours. In the follow-up study, there was an increase to 95% in those who had a CT scan done within 24 hours. With regards to routine diagnostic tests to detect cardiac abnormalities such as EKG, chest x-ray, and serum CPK, nearly all patients had these procedures done in both the baseline and follow-up studies (Table 1). There was an increase in the number of 2-D echocardiograms, carotid ultrasonograms, cerebral angiograms, and magnetic resonance angiograms (MRAs) in the follow-up results (Table 1).

There was a significant increase in the use of prophylactic measures to prevent deep-vein thrombosis in the follow-up study. These were mainly in the forms of subcutaneous heparin injection and wearing TED hoses. There was also a subsequent increase in the use of intravenous heparin infusion, although the difference did not reach statistical significance (Table 2). The administration of continuous heparin infusion was mainly for the management of the acute ischemic stroke with prevention of deep-vein thrombosis as a secondary treatment effect.

In the baseline study, 22% of stroke patients were treated acutely for hypertension and a majority (94%) received sublingual nifedipine. This is an area that was scrutinized and given attention very closely. Healthcare providers were educated regarding the possible risks in worsening the stroke following acute reduction of systemic blood pressures. In the follow-up study, no patients were treated emergently for their hypertension (Table 3).

At the time of discharge from the hospital, the majority of patients were placed on drug treatments (antiplatelets or anticoagulants) for the prevention of stroke recurrence. There was a further increase in the number of patients placed on such treatments in the follow-up study, although the difference did not reach statistical significance (Table 4).

Discussion

Clinical pathways are tools for patient care management, and these can be applied either in an in-patient

hospital setting or in an out-patient environment. A clinical care pathway contains a set of plans and provisions for the delivery of healthcare services in a timely and efficient manner. It optimizes utilization of available resources, maximizes the quality of medical care, and at the same time minimizes the costs. The clinical pathway starts at the moment the patient is being admitted to the hospital and continues throughout the episode of the medical illness until the patient is discharged from the hospital. It coordinates and streamlines the patient's care among physicians and other healthcare providers in fixed and targeted time frames, according to interdisciplinary guidelines formed from predetermined sets of standards.

When JARMC decided to develop its own sets of patient care pathways, the stroke clinical pathway was chosen as the initial or pilot project to determine their efficacies. At the time, JARMC was already part of an on-going collaborative study on ischemic strokes with the Mississippi Foundation for Medical Care. Among other

aspects of clinical care and procedures, the above-mentioned five clinical indicators were emphasized and employed in the stroke clinical pathway. These formed the criteria for comparisons between the baseline (pre-pathway) and the follow-up (post-pathway) studies (Tables 1 to 4). These clinical criteria contained guidelines that are endorsed by the American Heart Association for the management of acute ischemic stroke².

Following the implementation of the stroke clinical pathway, there was a significant increase in the proportion of brain CT scans performed within 24 hours (95%). The CT scan is an essential diagnostic procedure in the initial evaluation of an acute stroke. It can differentiate whether the stroke is ischemic or hemorrhagic in nature and will determine what type of treatment is necessary. For an example, an acute intracerebral hematoma may require a surgical evacuation of the blood clot. On the other hand, if anticoagulation or thrombolytic therapy with tissue plasminogen activator (TPA) is contemplated

Table 1. Diagnostic procedures that were performed on stroke patients.

Diagnostic Procedure	Baseline Study No.	Baseline Study Percent	Follow-Up Study No.	Follow-Up Study Percent	p-Value
Brain CT Scan	70	96%	63	94%	NS
(done within 24 hours)	53	76%	60	95%	0.0017
EKG	68	93%	63	94%	NS
Chest X-Ray	70	96%	65	97%	NS
Serum CPK	73	100%	64	96%	NS
2-D Echocardiogram	46	63%	57	85%	0.0031
Carotid Ultrasound	53	73%	60	90%	0.0111
Cerebral Angiogram/MRA	6	8%	25	37%	<0.0001
Total Number of Patients: (NS = not statistically significant)	73	100%	67	100%	

in the treatment of the cerebral ischemia, a CT scan is required to exclude the presence of an intracranial bleed. It is important that the scan should be performed as soon as it is available, preferably within 24 hours. If thrombolytic therapy with TPA is contemplated, the results of the brain CT scan should be available within three hours³.

patients presenting with stroke. In the follow-up (post-pathway) study, no patients were treated acutely for hypertension. This is a very significant achievement, since one of the primary aims of the Stroke Management Quality Improvement Project was to educate healthcare givers against the routine treatment of hypertension in

Table 2. Types of prophylactic procedures that were utilized to prevent deep-vein thrombosis in stroke patients.

Type of Prophylaxis	Baseline Study		Follow-Up Study		p-Value
	No.	Percent	No.	Percent	
TED Hose	4	5%	11	16%	0.0366
Subcutaneous Heparin	2	3%	8	12%	0.0347
IV Heparin Infusion	15	21%	22	33%	NS
At Least One of the Above	20	27%	35	52%	0.0026
Total Number of Patients: (NS = not statistically significant)	73	100%	67	100%	

After implementing the clinical pathway, there is also a significant increase in the utilization of available diagnostic procedures for determining the etiology of the cerebral ischemia, whether it is cardio-embolic (2-D echocardiography) or arterial in origin (carotid ultrasonography, cerebral angiography, MRA); see Table 1. The post-pathway study results also indicate a significant increase in the use of preventive measures against deep-vein thrombosis (Table 2).

The American Heart Association Guidelines recommend that systemic hypertension should not be treated during the acute phase of the ischemic stroke, unless the blood pressure is so extremely high that it may lead to a hypertensive crisis or an encephalopathy². The acute reduction in the systemic arterial blood pressure may diminish cerebral blood flow to an already ischemic brain and could worsen the stroke. In the baseline study, 22% of the stroke patients were treated for their hypertension, and the majority were given sublingual nifedipine (Table 3). The effect of sublingual nifedipine on the systemic hypertension can be erratic and difficult to titrate against the blood pressure. At times, it can induce a precipitous fall in the blood pressure and should be avoided in

acute ischemic stroke.

The average length of stay (LOS) of stroke patients in the hospital from 1993 to 1994 was 8.91 days. The average LOS was reduced to 6.27 days in 1995 to 1998 after the stroke clinical pathway was implemented on January 1, 1995. A cost-analysis of the average hospital charges incurred by stroke patients in the six-year period between January 1, 1993 and December 31, 1998, showed no major differences in the amounts when adjusted for inflation. The mean hospital cost for stroke in 1998 was 17.4% higher than the mean cost in 1993. This reflects an average increase of less than 3% per year in the last six years and is well within the range in the annual rates of inflation.

The follow-up study indicates a significant improvement in all the clinical parameters that were felt to require further attention, and none developed a setback subsequent to implementation of the stroke clinical pathway. It appears that more patients were undergoing different diagnostic procedures and receiving more treatment modalities for the acute stroke, while at the same time the duration of hospitalization was correspondingly shortened. This implies that the hospital's resources may

Table 3. Acute treatment of hypertension in stroke patients.

	Baseline Study No.	Baseline Study Percent	Follow-Up Study No.	Follow-Up Study Percent	p-Value
No. of Patients Treated	16	22%	0	0%	<0.0001
No. Treated With Sublingual Nifedipine	15	21%	0	0%	
Other Drugs	1	1%	0	0%	
Total Number of Patients:	73	100%	67	100%	

have been mobilized more efficiently when dealing specifically with a stroke patient. Although the diagnostic and therapeutic procedures performed on each patient may have increased following implementation of the clinical pathway, the average hospital costs have not correspondingly increased. The costs in the increased procedures may have been offset by the shorter period of hospitalization and from reduced medical complications

resulting from more improved and efficient delivery of patient care. In terms of cost-benefit analysis, the use of a clinical pathway maximizes the quality of medical care while at the same time minimizing the amount of expenditures.

Since the inception of the stroke clinical pathway, JARMC had developed similar pathways for various types of medical and surgical conditions. There are

Table 4. Preventive drug therapy at discharge for stroke patients.

Drug Therapy	Baseline Study No.	Baseline Study Percent	Follow-Up Study No.	Follow-Up Study Percent	p-Value
Warfarin	12	17%	14	22%	NS
Aspirin	42	59%	32	49%	NS
Ticlopidine	8	11%	15	23%	NS
At least one of the above	59	83%	60	92%	NS
Total Number of Patients: (Excluding Deaths)	71	100%	65	100%	

(NS = not statistically significant)

several obvious advantages in utilizing clinical pathways besides the planning and coordination of medical care and reducing costs. A well-documented clinical pathway standardizes the practice modalities of the different healthcare providers, reducing the variation in the delivery of medical care and clinical outcomes. It can provide an avenue for continuing education, research, and upgrading of standards of medical care as they emerge from time to time. A case manager can be assigned to oversee patients that are in the same pathway system and to coordinate these with the multidisciplinary healthcare givers involved in the cases. Finally, the patient and family can be informed intelligently as to what to expect in terms of treatment and diagnostic procedures, lengths of stay in the hospital, clinical outcomes, discharge plans, and hospital costs. These questions can be answered in the light of prior encounters with patients with similar illnesses and medical conditions in the clinical pathway.

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3. The National Institute of Neurological Disorders and Stroke t-PA Stroke Study Group. Tissue plasminogen activator for acute ischemic stroke. *N Engl J Med* 1995;333:1481-1587.

¹Department of Neurology,
University of Mississippi Medical Center
Jackson, Mississippi

²Performance Improvement Department, Jeff Anderson
Regional Medical Center
Meridian, Mississippi

³Information and Quality Healthcare
(Formerly the Mississippi Foundation for Medical Care)
Ridgeland, Mississippi

Address correspondence and reprint requests to:

A.S. Wee, M.D.
Department of Neurology
University of Mississippi Medical Center
2500 North State Street
Jackson, MS 39216

Address inquiries concerning the clinical pathways to: Performance Improvement Department
Jeff Anderson Regional Medical Center
2124 14th Street
Meridian, MS 39301

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Emergency Civil Commitment for Persons with Mental Illness

Philip Merideth, M.D., J.D.

The evaluation and treatment of persons with mental illness who are in need of emergency involuntary hospitalization has been at times a difficult task for Mississippi physicians and mental health professionals. Although Mississippi has laws that set forth procedures for the civil commitment (i.e., involuntary hospitalization) of mentally ill persons, physicians at times have found themselves in a difficult situation when attempting to evaluate or treat a mentally ill person in an emergency situation before civil commitment proceedings have been initiated. This difficulty has been due largely to the fact that until recently Mississippi physicians were not legally authorized to admit persons to a hospital against their will without a court order of civil commitment.

Persons with acute symptoms of mental illness may have impaired judgment or lack insight into the severity of their condition. These and other problems may present barriers to the effective evaluation and treatment of mentally ill persons in an emergency setting. In order to lessen the effect of such barriers, many states have passed laws that provide for the involuntary hospitalization of persons certified by a physician to be in need of emergency mental health treatment before a court order of civil commitment is obtained.¹

In the 2000 legislative session, the Mississippi legislature followed the lead of other states by enacting Senate Bill No. 2523, which was signed by the Governor and became effective on July 1, 2000. Senator Neely Carlton of Greenville sponsored this important legislation, which had the support of the Mississippi Psychiatric Association, the Mississippi Department of Mental Health, the Mississippi Psychological Association, and the Mississippi State Medical Association. This new law amends Section 41-21-67 of the Mississippi Code to allow for the involuntary hospitalization of mentally ill persons on a time limited, emergency basis without a court order of civil commitment.²

Senate Bill No. 2523 adds to Section 41-21-67 of the Mississippi Code a new subsection 5, which reads as follows:

Whenever a licensed physician or psychologist certified to complete examinations for the purpose of commitment has reason to believe that a person poses an immediate substantial likelihood of physical harm to himself or others or is gravely disabled and unable to care for himself by virtue of mental illness, as defined in Section 41-21-61(e), then the physician or psychologist may hold the person or the physician may admit the person to and treat the person in a licensed medical facility, without a civil order or warrant for a period not to exceed seventy-two (72) hours or the end of the next business day of the Chancery Clerk's office. Such person may be held and treated as an emergency patient at any licensed medical facility, available regional mental health facility, or crisis intervention center. The physician or psychologist who holds the person shall certify in writing the reasons for the need for holding. Any respondent so held may be given such treatment by a licensed physician as indicated by standard medical practice. Persons acting in good faith in connection with the detention of a person believed to be mentally ill shall incur no liability, civil or criminal, for such acts.

A few points about this new emergency civil commitment law are worthy of emphasis. First, the law states that emergency holding of mentally ill persons may be initiated by "a licensed physician or psychologist certified to complete examinations for the purpose of commitment." Therefore, the law grants emergency civil commitment authority only to physicians licensed to practice medicine in Mississippi and psychologists who have been certified to perform civil commitment examinations in Mississippi.

Second, in order to be held involuntarily in a medical facility under the provisions of this new law, the person must still meet criteria for civil commitment. The examining physician or psychologist must have reason to believe that the person is either mentally ill and likely to be

dangerous to himself or others, or is gravely disabled and unable to care for himself due to mental illness.

Third, the law grants both physicians and psychologists the authority to hold in a medical facility a person who is already admitted (e.g., an inpatient who demands to leave the facility against medical advice). However, the law authorizes only physicians (not psychologists) to admit and treat a mentally ill person as an emergency patient. Although the law authorizes psychologists to hold already-hospitalized persons against their will, the law does not authorize psychologists to order persons to be admitted to or treated at a medical facility. Therefore, the law does not create a new right for psychologists to have admitting or treating privileges at medical facilities.

Fourth, although the law clearly authorizes involuntary admission and treatment in an inpatient setting, the law does not state what type of facility is appropriate for this purpose, except to specify that persons may be held and treated at "any licensed medical facility, available regional mental health facility, or crisis intervention center." Section 41-21-67(4) of the Mississippi Code states that persons believed to be mentally ill shall not be held in a hospital directly operated by the Mississippi Department of Mental Health during the pendency of their civil commitment proceedings. When read in conjunction with Section 41-21-67(4), the new statutory language of subsection 5 apparently excludes hospitals directly operated by the Department of Mental Health as an appropriate setting for involuntary emergency civil commitment without a court order. Therefore, state mental hospitals such as the Mississippi State Hospital at Whitfield are not appropriate places for persons to be held on an emergency basis while awaiting civil commitment proceedings.

Fifth, although not explicitly stated, the new statutory language of subsection 5 clearly implies that mentally ill persons may be held involuntarily in medical facilities without a court order only for a long enough period of time for civil commitment proceedings to be initiated. The law sets an explicit limit of seventy-two hours, or the end of the next business day of the Chancery Clerk's office (whichever period is greater), as the length of time that a person may be held involuntarily in a medical facility without civil commitment proceedings being initiated.

Sixth, although the law clearly implies that civil commitment proceedings should be initiated in a timely manner, such proceedings may not be necessary in every case. For example, a mentally ill person may be evaluated and/or treated and be ready for discharge within seventy-two hours. Or, a mentally ill person who initially was held or admitted involuntarily may decide within seventy-two hours to continue treatment in the medical facility as a voluntary patient. In either case, civil commitment proceedings would not be required.

Seventh, the law grants civil and criminal immunity to persons who act in good faith in holding mentally ill persons pursuant to the law. Therefore, a person who was held erroneously, but in good faith, could be barred from obtaining a criminal conviction or recovering civil damages from the persons who held them pursuant to the law, if the defense of immunity is asserted.

Eighth, the law states that the examining physician or psychologist must certify in writing the reasons that the person needs to be held involuntarily. Contrary to the emergency civil commitment laws in some states, Mississippi's new law does not specify what information the physician or psychologist must include in the certification of the need for emergency holding. A model form for a Physician's or Psychologist's Emergency Certificate is set forth in Appendix 1. This form, which is based on the author's experience in completing physician's emergency certificates in Connecticut and Ohio, will serve as a guide for physicians and psychologists to document their examination and to certify why the person needs to be held in a medical facility against their will. The use of a Physician's or Psychologist's Emergency Certificate will serve the interests of both patients and treaters, by ensuring that patients' rights are protected and that treaters are covered by the immunity provided by the law. Once completed, the Physician's or Psychologist's Emergency Certificate should become part of the person's medical record, and also may be provided to the court to document the need for civil commitment.

Last, in cases in which a mentally ill person in need of emergency involuntary hospitalization presents to a doctor's office or an outpatient clinic, emergency personnel such as law enforcement officers or EMT's may have to be called to transport the person to an appropriate medical facility after a Physician's or Psychologist's Emergency Certificate is completed.

In summary, Mississippi Code Section 41-21-67, as amended by the recently-enacted Senate Bill No. 2523, gives licensed physicians and appropriately certified psychologists the emergency, time-limited authority to hold involuntarily in a medical facility mentally ill persons who are either likely to be dangerous or are gravely disabled due to mental illness. Under the provisions of this new law, mentally ill persons should be able to get appropriate treatment more quickly. Physicians, psychologists, employees of psychiatric facilities and emergency rooms, emergency personnel such as law enforcement officers and EMT's, and medical facility administrators should familiarize themselves with the specific provisions of this new law. Medical facilities may wish to formulate policies and procedures, such as adopting a Physician's or Psychologist's Emergency Certificate, to ensure that the

Appendix 1— Model Form for Physician's or Psychologist's Emergency Certificate, Page 1

Physician's or Psychologist's Emergency Certificate			
Name of Person Examined (Examinee)	Date of Birth	Age	Sex
Address and Telephone of Examinee	Social Security Number of Examinee		
Name, Address, and Telephone of Nearest Relative, Guardian, or Friend	Relationship		
Date, Time, and Place of Examination			
Examinee's Mental Health History			
Examinee's Current Mental Status			
I certify that based on my examination of the person named above, I am of the opinion that pursuant to Section 41-21-67(5) of the Mississippi Code, the examinee should be admitted to (or held at) _____ . (Insert the name of a licensed medical facility other than a hospital directly operated by the Mississippi Department of Mental Health)			
I certify that the reason for my opinion is that: (Check appropriate box)			
<input type="checkbox"/> the examinee is mentally ill and poses an immediate substantial likelihood of physical harm to himself/herself or others.			
<input type="checkbox"/> the examinee is gravely disabled and unable to care for himself/herself by virtue of mental illness.			
I further certify that this examination was conducted in good faith and that I am a: (Check appropriate box)			
<input type="checkbox"/> physician licensed to practice medicine in Mississippi.			
<input type="checkbox"/> psychologist certified to complete examinations for the purpose of civil commitment in Mississippi.			
Printed Name of Examining Physician or Psychologist	Signature of Examining Physician or Psychologist	Date and Time of Signature	
Page 1 of 2			

provisions of the law are carried out correctly. Use of the model form for a Physician's or Psychologist's Emergency Certificate that is contained in Appendix 1 is encouraged.

This article was written for medical education purposes only and should not be considered legal advice. The information in this article should not be relied upon without consulting an attorney.

REFERENCES

1. For example, see Ohio Revised Code Annotated, Section 5122.10 and Connecticut General Statutes Annotated, Section 17-183.
2. Mississippi Code Annotated, Section 41-21-67 (amended July 1, 2000).

Philip Merideth, M.D., J.D. is a forensic psychiatrist at the Mississippi State Hospital and a Clinical Assistant Professor of Psychiatry at the University of Mississippi Medical Center. He also serves as an Adjunct Professor of Law at the Mississippi College School of Law.

Address correspondence to: Philip Merideth, M.D., J.D.
Post Office Box 97111
Jackson, MS 39288

Appendix 1 continued — Model Form for Physician's or Psychologist's Emergency Certificate, Page 2

The Physician's or Psychologist's Emergency Certificate printed on Page 1 of this form is to be completed pursuant to the provisions of Section 41-21-67(5) of the Mississippi Code, which states:

"Whenever a licensed physician or psychologist certified to complete examinations for the purpose of commitment has reason to believe that a person poses an immediate substantial likelihood of physical harm to himself or others or is gravely disabled and unable to care for himself by virtue of mental illness, as defined in Section 41-21-61(e), then the physician or psychologist may hold the person or the physician may admit the person to and treat the person in a licensed medical facility, without a civil order or warrant for a period not to exceed seventy-two (72) hours or the end of the next business day of the Chancery Clerk's office. Such person may be held and treated as an emergency patient at any licensed medical facility [*with the exception of a hospital directly operated by the Mississippi Department of Mental Health, as stated in Mississippi Code Section 41-21-67(4)*], available regional mental health facility, or crisis intervention center. The physician or psychologist who holds the person shall certify in writing the reasons for the need for holding. Any respondent so held may be given such treatment by a licensed physician as indicated by standard medical practice. Persons acting in good faith in connection with the detention of a person believed to be mentally ill shall incur no liability, civil or criminal, for such acts."

Valedictory Address
W. Briggs Hopson, Jr., M.D.
132nd Annual Session
May 19, 2000



W. Briggs Hopson, Jr., M.D.

Footprints in the Sand of Time

Mr. speaker, delegates, fellow physicians, and guests- good morning and welcome to the 132nd annual session of the Mississippi State Medical Association. My year began last year with my forgetting to introduce the leading lady in my life, my wife Pat. So lest I forget again, let me thank her for her tremendous support this year. However, this is nothing new to her, for she has been the wind beneath my wings for over 40 years.

Today is a sad day for me because I know it signals the end of the greatest year of my life. Oh yes, I have had some great moments, some great days, some great weeks, but never a year like this one. Seriously, I really hate to think that it is about over. The year has been a lot like having 365 days of Christmas. I know a number of you may think I am crazy for feeling this way, but I wish all of you could have had the opportunity that I have had this year. I am certain that the past presidents in the audience will agree with me that this year opens doors and thresholds that few have had the opportunity to pass through, and for that I am extremely grateful.

Think of this! For one year I have had the opportunity to travel across our great state to visit and speak to component medical societies about state and national medical issues that affect all of us who practice medicine. While there, I have also had the opportunity to see friends, exchange stories and ideas, meet new friends, and get advice from my colleagues.

I have had the opportunity to travel to Washington on several occasions and talk with our congressional delegation about the patient bill of rights, about collective bargaining, and many other issues that face the nation with regard to medical practice.

I have also had the opportunity to go with the hospital delegation and discuss the Balanced Budget Act, about putting money back into programs that affect all of the citizens in this state. I cannot tell you how much fun I have had challenging our delegation to do what is right for the citizens of the state of Mississippi.

What a joy and a privilege it has been to write the president's page each month, the opportunity to share my thoughts and ideas with each of you... Hopefully, thoughts that you could use in your practice or in your day-to-day living.

- And to be the president when we opened our new house of business, our new home in Ridgeland, to have the opportunity to cut the ribbon and to share this momentous occasion with each of you present on that day.

- To serve as doctor of the day on the first day of the new legislative session when, for the first time in history, the House of Representatives had to decide a contested election, to stand on the floor and listen as all votes were counted for our present governor.

• To again have the opportunity to work with all of you to defeat those who would introduce bills which would infringe upon the scope and the practice of medicine.

• To meet with the new governor and to talk with him about his ideas on patient care in Mississippi, and to talk with him about ways that we can work together in the future.

• To have had the privilege of appointing the third party liaison committee, a committee that wants to help you resolve your problems with the insurance companies of this state.

• To have put together a group of physicians to meet with pharmacists to discuss medical management as suggested by our legislature.

• To have had 80% of the component society presidents come to Jackson to discuss ways we could increase local participation and local involvement by area physicians.

• To continue to serve on the MPCN board, to see it grow stronger and stronger as it signs up more business and more companies, not only in this state but in surrounding areas.

• To have had the opportunity to travel to the AMA meeting and sit as an alternate delegate on the floor, to have the opportunity to witness a classic discussion and vote as physicians around the country made a decision on collective bargaining.

• To work with your delegation at the AMA to reelect Ed Hill to the AMA board of trustees.

This list could go on and on but these are just a few of the things I know made my year a memorable one. But time moves on and we can never recapture the past so let us look at what we can accomplish today.

Last year I challenged each of you to look in the mirror and ask yourself three questions. First, have I been more politically involved today? Second, have I encouraged a young physician to get more involved in the political aspect of medicine? Third, have I recruited someone for our Mississippi State Medical Association? As I look at the scorecard, and as I look around the room, I think you can give yourself an "A" for doing the things that you told me you would do this year. However, you must remember that this test, this challenge does not stop with my handing the gavel over to our new president, for this test, this challenge is perpetual, one that you must take each year until you hang up your stethoscope and leave the practice of medicine.

Yes, we increased our membership; yes, we have more young physicians involved; yes, we have increased

the number of people in MMPAC, but we have not come close to reaching our total potential and capabilities.

Next year we will face a real challenge on many fronts. First we must decide how we will deal with the nursing board and the nurse practitioners. I have appointed a committee to meet with the state licensing board, the nursing licensing board, and legislative leaders to try to come up with a reasonable solution regarding nurse practitioners in our state. We cannot bury our heads in the sand like the ostrich and think that this problem will go away or that we can win each time that this or a new bill comes to the floor of the legislature. We must stop playing defensive football and mount an offensive challenge that will take us to the goal line. We must have options that will protect the practice of medicine and allow us to control what the paramedical people do. We must have options that we can live with which give us control over the practice of medicine. We must have options that show people that we care, that we serve, and that we are their advocates.

The next problem we will face for next year deals with elections, both local and national. We must get more members in our political action committee. I am certain that most of you in the audience realize only 36% of our membership belongs to the political action committee. Think of what we could do if 100% of our membership belonged to the political action committee. I ask all of you sitting in the audience if you do not belong to **AMPAC** or **MMPAC**, please join today and encourage all of your colleagues to join today. We must get more involved in the political process.

Our present governor told me he had very little support among physicians and the fact that he is aware of this and continues to want to work with us tells me that he is interested in promoting health care. However, he is asking us to show support both in numbers and financially. He has asked that we come and sit around the table, and discuss ideas and thoughts that will take us and move us forward over the next four years. We have a supreme court and appellate court race coming up this year, and we must elect judges who are friendly to medicine. All of you sitting in this audience are aware that two years ago we lost two critical seats on the court of appeals. Both courts are now controlled by the trial lawyers and when issues facing medicine come up, rest assured that the person defending the physician will come in second.

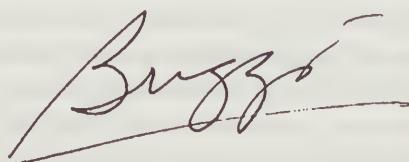
In November national elections are coming. These elections will affect medicine nationwide over the next four years. We must ask all of those running their opinions on the patient bill of rights, and we must elect leaders who put patients before party. Not only must we do this

but also we must challenge and ask our patients to do this. In order to accomplish these political goals, I am asking each of you to consider giving 1/2 to 1 percent of your income to political action this year. I can assure you that money makes a difference. However, it is not the only thing. We must have personal contact, we must work for candidates, and encourage our friends throughout the state to write when we have issues that affect medical practice.

Lastly, let me encourage all of you to support the American Medical Association. The American Medical Association speaks for all physicians and wants input from all of us. It is an organization that is totally run by physicians. It is an organization that is totally controlled by physicians from California to New York and from South Dakota to Florida, an organization that takes in all venues of practice and all problems of practice. It is an organization run as a democracy, an organization where we have the chance for input and also have the opportunity to learn from our colleagues around the country. By working in an organized structure, and only through an organized structure, can we totally control outcomes both politically and nationally. I am certain that all of you realize, with the changes taking place in medicine, we must have an organization that works not only through us but with us as we continue to move forward in our quest for providing better health care for our patients and fellow citizens.

I would like to close with the last few lines of the poem *Psalm of Life* by Wordsworth. "Lives of great men all remind us we can make our lives sublime and departing leave behind us footprints in the sand of time. Footprints that perhaps another sailing o'er life's solemn mien a shipwrecked and forlorn brother seeing will take heart again. So let us then be up and doing with a heart for any faith, still achieving, still pursuing, learn to labor and to wait."

I ask you - have you laid down your footprints?



Medical Practice Services on the Horizon

MSMA and the law firm of Butler, Snow, O'Mara, Stevens and Cannada have entered a "strategic partnership" that provides expanded legal and practice management services to MSMA members. Butler, Snow is a full service law firm with over 90 attorneys in Jackson, the Gulf Coast and in Memphis, Tennessee.

The opportunity offers a "one stop shopping" concept which provides legal, practice assessment and practice management services to physicians on a consistent and value added basis. The services, designed to meet all of the day-to-day needs of physicians which cannot be readily addressed by existing MSMA staff, will include:

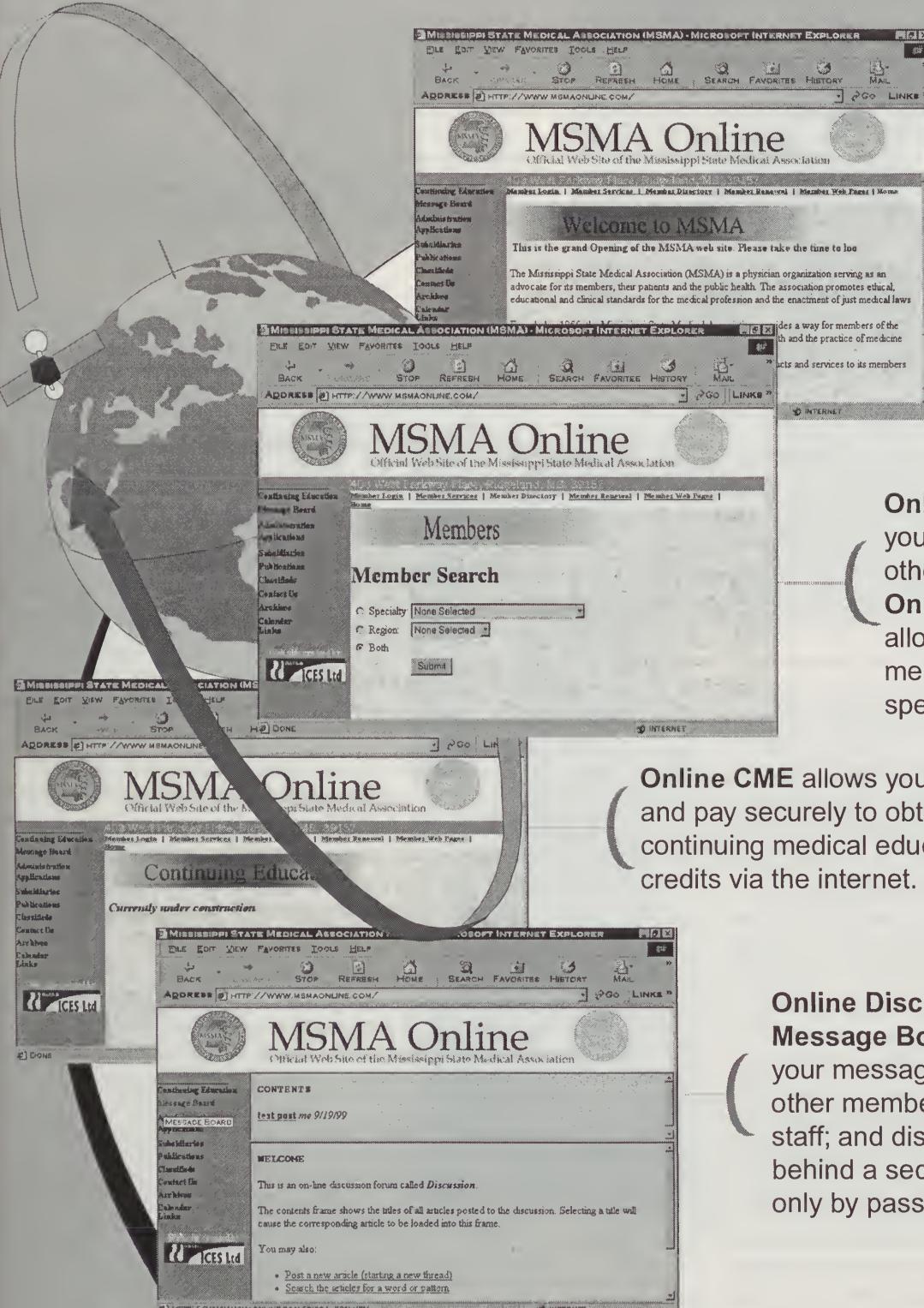
- contract negotiation
- corporate compliance
- billing and accounts receivable services, including CPT code evaluation
- post payment audits, focused medical reviews and other issues with respect to the Medicare and Medicaid
- market studies, including patient demographics
- mergers and acquisitions
- employment issues
- physician practice and employment contracts and agreements
- tax and estate planning

The strategic partnership calls for Butler, Snow to contract directly with MSMA Diversified, Inc., which will serve as an interface and liaison between MSMA members and the law firm. The law firm has agreed to work with MSMA on a fixed fee basis whenever possible. Diversified will negotiate the lowest possible fee for those instances in which a fixed fee is not possible or desirable.

Brochures outlining the new products and services have been distributed. If you have questions or comments, please call Linda McMullen, MSMA General Counsel, phone: (601)853-6733, extension 310, or toll free: 1-800-898-0251.

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Inaugural Address
Candace E. Keller, M.D., M.P.H.
132nd Annual Session
May 20, 2000

Our Past... Our Present... Our Future...

Our Past... The Mississippi State Medical Association was begun in 1856 by a handful of physicians who first met in Jackson. It was their intention to meet annually, but they did not reconvene until 1869. Thus, this weekend marks the one hundred thirty second meeting of this organization. Those doctors met back then to discuss their interesting cases as well as a variety of public health diseases plaguing Mississippi. They discussed ways to address those health concerns and thereby improve the health and well being of their patients.

When we look back in time, we realize that being a physician was not easy then either. Although the hardships and challenges they faced were far different than ours today, the practice of medicine has always been demanding and fraught with obstacles to be overcome. Indeed, being a physician has always been more than a job or avocation. It is a calling. And just as those doctors in 1856 felt the need to join together then, we too, must band together now as never before.

Which leads us to the present... Today, in the year 2000, we are an organization of over 3,000 strong, capable, and caring physicians. Our Mis-

sissippi Physicians Care Network is growing and prospering. Our staff, led by Mr. Bill Roberts, is second to none. Our Alliance is the greatest in the nation!

We too, though, are confronted by medical diseases yet to be conquered. Cancer, heart disease, diabetes -- to name only a few, are prevalent here. Only 37% of women over the age of fifty in Mississippi receive a mammogram at least once every two years! Only 51% of Medicare diabetics get a hemoglobin A1C monitoring test at least once a year! Only 47% of eligible heart attack patients are discharged on beta blocker medications. There is much that we can do to improve the health and quality of life for our patients here in Mississippi. This year I'll be challenging each of you to reexamine your processes of care to find new and innovative ways to improve our service to our patients.

In this present time, we also find ourselves beset by other problems too... intrusion by government, by managed care and by insurance entities. Intrusions by those who seek to reap the benefits of our profession but who have not paid the price. Unwilling to spend four years in medical school-- Unwilling to spend four to six years in residency



Candace E. Keller, M.D., M.P.H. at the MSMA President's Inaugural Celebration. A dinner dance was held following in conjunction with the MSMA Alliance Auction, a benefit for the AMA Foundation.

training... Unwilling to spend time away from family, friends, and personal pursuits.

The age-old strategy of divide and conquer is alive and well. It continues to be levied against us in an attempt to weaken and control. But... there is great strength in numbers. Although our battles may differ by locale or specialty, I challenge you to support one another.

Stand firmly together. United we stand; divided we fall!

Which brings us to the future. The promise of great scientific breakthroughs in research and medical therapy is close at hand. The promise of a meaningful patients' bill of rights, antitrust relief, and tort reform is closer than ever.

None of us knows for certain what the future may bring. But we do know that... what we choose to believe..., what we choose to say... and the actions we choose to take now -- in the present -- will greatly influence, impact, and indeed determine what our future will be.

In the final analysis, the past, the present, and the future are really all about living, loving, and leaving a legacy. As we look ahead, I challenge each of you to live every day to the fullest extent possible. Granted, some days will be better than others, but each day is a new day and an opportunity to begin again.

I challenge each of you to take time every day to demonstrate your loving spirits in some way. Whether a kind word, a good deed, or simply the touch of a hand... Let your families, friends, and patients know you care.



Dr. Keller's mother, Ann Keller; her niece, Leslie Ann; Dr. Keller; her nephew, John Michael and her father, Dr. William R. (Bill) Keller.

And lastly, I challenge each of you to leave a legacy... These children are the pride and joy of our family! Meet my niece, Leslie Ann, who is five, and my nephew, John Michael, who is seven. We don't yet know whether they will choose to become doctors or pursue some other field as their life's work. But whether they become givers of medical care or are recipients of it, our challenge is to leave them the legacy of a profession and a health care system of which both they and we can be proud!

Thank you for sharing this great evening with me. I look forward to serving you and working with each of you in the coming year!

Candace

MSMA Concludes 132ND Annual Meeting

The association conducted its 132nd Annual Session of the House of Delegates at the Beau Rivage Resort on May 19-21. A total of 248 physicians attended the meeting, which was the largest number of to register for an Annual Session in Biloxi since 1991. The annual educational program, "*Medical Affairs Forum 2000*", included CME credits on topics that included litigation stress, drafting physician-oriented medical staff bylaws, the Mississippi Recovering Physicians Program, an update on Congressional health care legislation, and an update on the latest advances in eye surgery.

Among the numerous operational and public policy actions taken by the House of Delegates during its two sessions were the following:

- Adopted MSMA Constitution and Bylaws amendments extending active membership and representation on the association's Board of Trustees and Councils to medical students and residents/fel-

lows;

- Officially commended Dr. W. Briggs Hopson, Jr. for his outstanding accomplishments while serving as the association's President in 1999-2000;
- Adopted a report of the Board of Trustees recommending that the existing disciplinary processes of both MSMA and the Mississippi Board of Medical Licensure be used to address potential violations of ethical requirements related to charges for laboratory services, in lieu of supporting special legislation to deal with the issue;
- Asked the Board of Trustees to study Mississippi's current Certificate-of-Need laws and report to the House of Delegates in 2001 on whether the law should be repealed or modified;
- Directed the association staff to provide increased advice and counsel to hospital medical staffs and to conduct an annual educational program for medical staff officers;
- Asked the Board of Trustees to study the present Medical Examiner system and recommend necessary changes in the law that would enable it to function more effectively;
- Urged Mississippi's Congressional delegation to support institution of a program to provide elderly military retirees with high quality health care;
- Asked the Board of Trustees to study and report back to the House of Delegates on the advantages and disadvantages of enacting legislation to declare medical staff bylaws to be a binding contract between a hospital and the members of its medical staff;
- Asked the Board of Trustees to study and report back to the House of Delegates on a compreh-

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hensive package of medical liability reforms, including the establishment of a state patient's compensation fund;

- Urged the Mississippi Press Association and the Mississippi Broadcaster's Association to encourage their members to routinely provide information on seatbelt usage in reporting on motor vehicle accidents; and

- Asked the Board of Trustees to develop CME-accredited programs for joint sponsorship with MSMA component medical societies.

New dates have been set for the year 2002 and 2003 annual meetings which are both also scheduled to be held at the Beau Rivage. They are May 31-June 2, 2002 and May 30-June 1, 2002.

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MSMA Past-President W. Briggs Hopson, Jr., M.D., MSMA President Candace E. Keller, M.D. and MSMA President-Elect Hugh A. Gamble, II, M.D.

Keller Assumes Presidency... New officers Elected

Dr. Candace E. Keller, a Hattiesburg anesthesiologist with a masters in public health administration, was installed as the association's 132nd President in special inaugural ceremonies held for the first time at a dinner/dance on Saturday evening during the meeting. A Greenville surgeon, Dr. Hugh Gamble, was chosen by delegates as the President-elect, thus following in the footsteps of his father and grandfather who also served as President of MSMA.

In other election matters, Dr. John F. Lucas, III (Greenwood) was elected to serve as Dr. Gamble's replacement on the Board of Trustees from District 2, while Dr. Steve Parvin (Starkville) was re-elected to second term on the Board of Trustees from District 3.

At its organizational meeting after the elections, the Board of Trustees elected Dr. Steve Parvin to a second term as its Chairman. Dr. John Cook (Jackson) was elected Vice Chairman of the Board, while Dr. Ben Carmichael (Hattiesburg) was re-elected to a second term as Secretary. These three officers comprise the Board's Executive Committee.

Other terms filled by re-election or nomination include the following:

Delegate to AMA - Term 2001-2002

Candace E. Keller, M.D., M.P.H., Hattiesburg

Alternate Delegate to AMA - Term 2001-2002

W. Briggs Hopson, Jr., M.D., Vicksburg

Delegate to AMA - Term 2001-2002

George E. McGee, M.D., Hattiesburg

Alternate Delegate to AMA - Term 2001-2002

H. Vann Craig, M.D., Natchez

Delegate to AMA - Term 2001-2002

James S. McIlwain, M.D., Clinton

Alternate Delegate to AMA - Term 2001-2002

Helen R. Turner, M.D., Jackson

Associate Editor, Journal MSMA - Term 2000-2002

D. Stanley Hartness, M.D., Kosciusko

Council on Budget and Finance - Term 2000-2003
John J. Cook, M.D., Jackson

Council on Budget and Finance - Term 2000-2003
Clark G. Warden, M.D., Pascagoula

Council on Constitution & Bylaws - Term 2000-2003
Lee Voulters, M.D., Vicksburg

Judicial Council, District 6 - Term 2000-2003
A. Jerald Jackson, M.D., Hattiesburg

Judicial Council, District 7 - Term 2000-2003
F. Thomas Carey, Jr., M.D., Natchez

Judicial Council, District 8 - Term 2000-2003
Donald K. Gaddy, M.D., Gulfport

Council on Legislation, District 4 - Term 2000-2003
J. Martin Tucker, M.D., Jackson

Council on Legislation, District 5 - Term 2000-2003
Dewitt G. Crawford, M.D., Louisville

Council on Medical Education, District 6 - Term 2000-2003
Michael G. May, M.D., Hattiesburg

Council on Medical Education, District 7 - Term 2000-2003
F. Thomas Carey, M.D., McComb

Council on Medical Education, District 8 - Term 2000-2003
Edward J. Shumski, M.D., Biloxi

Council on Medical Service, District 6 - Term 2000-2003
John F. Hassell, M.D., Laurel

Council on Medical Service, District 7 - Term 2000-2003
Joe M. Ross, Jr., M.D., Vicksburg

Council on Medical Service, District 8 - Term 2000-2003
Donald W. Benefield, M.D., Gulfport

Council on Public Information, District 7 - Term 2000-2003
Susan A. Chiarito, M.D., Vicksburg

Council on Public Information, District 8 - Term 2000-2003
Joseph R. Mitchell, M.D., Gulfport

Chairman, Medical Planning Group - Term 2000-2003
John E. Moffitt, M.D., Jackson



MSMA President-Elect Hugh A. Gamble, II, M.D. and his wife, Dawn.

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MSMA Alliance 77th Annual Session



Chair of the Medical Student/Resident Physician Committee Mary Sue Mitchell, MSMA Past-President W. Briggs Hobson, Jr., M.D. and MSMA President Candace E. Keller, M.D. wait for the opening ceremonies of the MSMA Alliance House of Delegates.



Nancy Lindstrom, member of the AMPAC Board; Mary Helen Schaeffer, MSMA Alliance Past-President and member of the AMA Foundation Committee; Jeanne Morrison, AMAA Field Director and Ann Hopper, MSMA Alliance President, will represent the MSMA Alliance on the national level for 2000-01.

The 77th Annual Session of the Mississippi State Medical Association Alliance met in conjunction with the MSMA at the Beau Rivage in Biloxi, May 18-21. Many people ask, "Why attend our Annual Session? Why belong to the Alliance?" Read on, and see how we are involved.

Not only do we renew old friendships; but also, there is ample time to develop new friends during our meetings. Under the leadership of then President of the MSMA Alliance, Mary Helen Schaeffer, as a vital part of a pilot American Medical Association Alliance (AMAA) membership program we completed our year with 1,293 members, a 12% increase. We will receive an award for this in Chicago.

We donated approximately \$38,000.00 to the American Medical Association (AMA) Foundation to be used for education and research in medical schools. Proceeds from Ann Hopper's book, *Get A Life*, contributed greatly to our total; also, the silent auction, the first annual favorite Mississippi art show, and the sale of 200 raffle tickets for a wonderful trip to Spain/Portugal increased our bottom line profit.

Through Health Choice, we touched the lives of 2,400 Mississippi children. We listened to speaker Penny Norton as she briefed us on the new Health Education alcohol project, "Facing Alcohol Concerns Through Education" (FACE). Promoting breast cancer awareness is always at the top of our projects, and once again, our Alliance was presented the first place award at Southern Medical Association Auxiliary for our work.

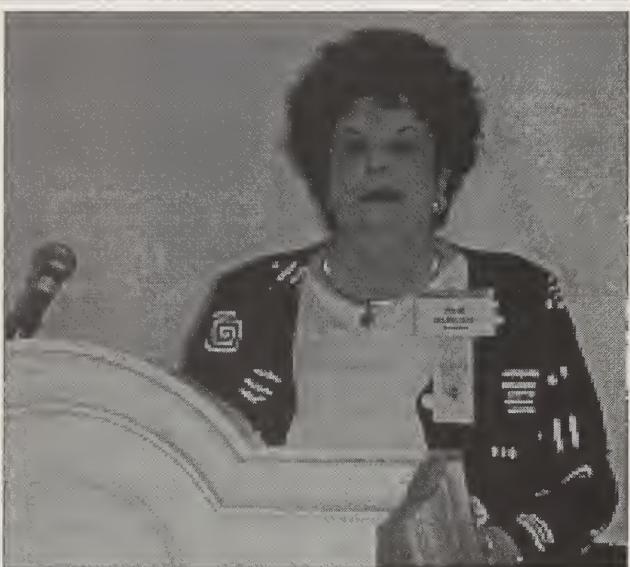
Annual Session attendees listened to Susan Padlock, AMA president-elect, give her program for 2000-01. Chip Reno, Executive Director of the Stop Law Suit Abuse in Mississippi program, presented a wonderful workshop on "Who's Passing Judgment?" We were entertained by guitarist, James Rankin, and four former Miss Mississippi's. We met and enjoyed Thomas Reardon, M. D., President of the AMA.

Our officers for 2000-01 are: Ann Hopper, President; Kim Reed, President-Elect; and Committee Chairs Eileen McRae, Peggy Spraberry, Susan Rish, Susan Pickard, Debra Carr, and Sharon Gill.

—*Mrs. Dewitt G. (Peggy) Crawford*



Penny Norton, National Director of FACE, a preventive alcohol program, spoke to Alliance members during their House of Delegates meeting.



Nell Middleton sang our national anthem at the opening ceremonies of the MSMA House of Delegates.



Kim Reed, President-Elect, and Ann Hopper, MSMA Alliance President and author of *Get A Life*, promote her book. Ann generously donated part of the proceeds of book sales to the MSMA Alliance.



**Candace E. Keller, M.D., M.P.H.
The President's Page**

Looking in the Mirror

“M_{irror, mirror on the wall...}”

They say that reflection is good for the soul and when done properly, I suppose that is true. For those of you who were able to attend the MSMA annual session May 19-21, 2000, I trust that your reflections are as positive as mine. For those of you who didn't make it, mark your calendars now for May 4-6, 2001.

This year's meeting was one of the most successful ever conducted by any measure. The attendance and participation of those present exceeded all previous expectations and achievements. Our business was efficiently and effectively conducted in a democratic manner which allowed both the minority and majority opinions to be heard. In the end, our House of Delegates once again gave us clear guidance and direction.

Our first annual inaugural dinner and dance was absolutely spectacular. From the outstanding entertainment to the exceptional art exhibit and auction by our Alliance, nothing could have been finer. I am pleased to report we raised over \$38,000 for the AMA Foundation through this event alone!

These are reflections of which we can all be proud. Let us now continue to build upon that spirit of collegiality and oneness we experienced there. I challenge each of us; however, as we look in the mirror individually during the coming year, to continually find new and better ways to enhance both our image and performance in our daily lives and our profession.

I received a sage piece of advice many years ago as a resident physician. We had worked for several hours to save a newborn with a serious congenital heart defect. We had been unsuccessful and the patient expired. My attending called me into his office and reminded me that situations don't always turn out the way we would choose. But when we've done the right things to the best of our ability, we can face ourselves squarely knowing we did all we could regardless of the outcome.

None of us is perfect, but we can all continue our quest for learning improvement, and excellence. Then at the end of the day, we can each look in the mirror and say:

“Mirror, mirror on the wall,

Today I did my best for all.”

Editorial

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XLI, NUMBER 7
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MISSISSIPPI'S BRIDGE BUILDER: DR. VERNER S. HOLMES (1909-2000) REMEMBERED

"Dr. Verner Holmes was a great man. He honored his public trust with a fidelity that I have not seen with any other Mississippian...Everybody loved Dr. Holmes. He looked better the closer you got to him. Others have flaws that become apparent the closer you get. But the closer you got to Dr. Holmes, the more you loved and admired him."

— Professor David G. Sansing

Ole Miss Emeritus Professor of History

One of Mississippi's noblest sons, Dr. Verner Smith Holmes, died of heart failure following a stroke on Sunday night May 21, 2000 at Hospice Ministries in Ridgeland. Holmes, 90, a McComb physician specializing in otolaryngology (ENT), influenced both higher education and medicine in Mississippi for decades.

At funeral services on May 24th at McComb's J.J. White Memorial Presbyterian Church, the historic brick church which Holmes had long attended, the Rev. Dick Swayze discussed his respect for Holmes and lauded Holmes's "courageous stand for what he knew was right," during his period of service on the State College Board. He added that Holmes's wife Mary had told him, "Only God knows the people Verner helped along the way." Swayze also praised his "vision to rise above and see the larger picture."

Swayze then read a moving tribute to Holmes by his son Vern. Vern wrote, "We are here to celebrate a life fully lived and filled with achievement. A life that surely gave its full measure of devotion to family, friends, patients, this state's institutions of higher learning, especially the Medical Center, and our nation. His accomplishments are legend and remain an enduring tribute to his life. Sunday night Heaven truly received one of Christ's noble men...The world, quite simply, is a better place because he dignified this earth for 90 years."

Vern also graced his remarks with a poem entitled "The Bridge Builder." It told the story of an old man who "in the twilight dim" crossed a "chasm vast and deep and wide," and rather than continue on his journey, "turned when he reached the other side, and built a bridge to span the tide." When asked by a fellow traveler why he wasted his strength in such an effort, the old man said, "Good friend, in the path I have come, there followeth after me today, a youth whose feet must pass this way. This chasm that has been naught to me, to that fair-haired youth may a pitfall be. He too must pass in the twilight dim; Good friend, I am building the bridge for him."

The poem paid appropriate tribute to his father's accomplishments, for Verner Holmes, M. D. built bridges his entire life, spanning chasms between white and black, rich and poor, educated and uneducated, physician and patient, and teacher and student. He helped nineteenth century Mississippi medicine and medical education advance into the twenty-first century. The gallant journey of Mississippi's bridge builder provides an example of a life well-lived.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



Dr. Verner S. Holmes (1909-2000) made significant contributions to Mississippi medicine and higher education during his lengthy service on the State College Board. He is shown here in a portrait by Marshall Bouldin which hangs at UMC's Verner S. Holmes Learning Resource Center.

After the funeral service where Vern's tribute was read, the funeral procession filed in cars down McComb's Pennsylvania Avenue through the brick entrance into historic Hollywood Cemetery. Holmes was buried next to his first wife Emma in the Bauer lot, located in the old part of the cemetery, ironically near the grave of Dr. B. F. Gatlin (1836 –1878), another McComb physician who served his fellow man in a time of crisis (Gatlin was mayor of McComb and oversaw the city during the Yellow Fever epidemic of 1878, only to be one of the last to perish in the epidemic). Military personnel folded an American flag draped over Holmes's casket as Taps was played.

Dr. Holmes was born on July 10, 1909, at the home of his parents, the late Byron Berkley "B. B." Holmes and Dixie Smith Holmes, in what is now Walthall County (but then it was still Old Pike County). The small community in which he was born was called Lexie and was located

three miles south of Tylertown, on Highway 27 South. Although not wealthy, Holmes's family were the leading citizens in that community. Verner's grandfather John Wesley Holmes had operated a large mill, store and post office there, and when the New Orleans and Great Northern Railroad, later the Gulf Mobile and Ohio Railroad (which would run from Tylertown to Bogalusa and on to New Orleans), negotiated for a right-of-way, Wesley Holmes donated the land on condition that the company erect a station named for his daughter Lexie.

The Lexie of Verner Holmes's youth was a bustling village, with two large sawmills, three stores, a school, and a large Baptist Church. The G. M. and O. Railroad was active in the lumber trade, shipping timber, cross-ties, and farm produce to Bogalusa and Tylertown. The railroad ran a passenger "doodlebug" as well and operated a depot. The local timber would be harvested from the area by the early 1920s, and the village began a gradual decline.

Verner's father "B. B." was a successful farmer and followed his father as longtime postmaster of the village, as well as running a general store. In his later years, he would serve as a rural mail carrier in Walthall County. Verner was the eldest child of five children and the house the family grew up in is still occupied by his sister Iska. The Holmes family was close, with the parents each actively molding the children "with good instructions" in a "good Christian home," his brother Wendell recalls.

Verner was a good student in the local Lexie schools, and studied the violin, taking lessons in McComb. He took an active role in guiding his younger siblings, but was known for his jokes and humor. Brother Wendell remembers, "When we were growing up, we used to watch birds make nests on the ledge above the front porch columns at the house. He persuaded our brother Omer to climb up the column to the ledge to see the birds. When Omer put his hand up to the 'nest,' he discovered that Verner had replaced the nest with cow dung."

Friends in Tylertown jokingly called him "The Mayor of Lexie."

Critical in his decision to become a physician was his relationship with his Holmes cousin, Dr. A. B. Harvey of Tylertown. Harvey took an interest in his young kinsman and even helped finance his way through medical school. He went to Mississippi College for his undergraduate studies, and there Holmes saw for the first time a microscope. He obtained his B. S. and then went to Ole Miss's two-year medical school.

The old medical school at Oxford proved pivotal for Holmes in many ways. But most critical was his friendship with J. P. "Plemon" Coleman, a brilliant but dirt poor

plowboy from Choctaw County, who is the only man in the history of Mississippi to serve in all three branches of state government by election of the people. Plemon had found housing in the attic at the old chapel now the Croft Center. Verner lived in the same dormitory and the two soon connected with mutual interests. Early in their Ole Miss experience, Plemon told his friend, "Verner, someday I'm gonna be Governor." And to this Verner replied, "If you run, I'll support you," thus sealing a commitment which would be realized more than two decades later.

Brother Wendell remembers that Verner once reflected that his own family and background were "country," but that Plemon was "way country, no shoes, no money. But Verner took to that type." The two became lifelong friends.

After finishing his studies at Ole Miss, Holmes finished his last two years of medicine at Tulane Medical School. He then did a 2-year postgraduate training period at Johns Hopkins in Baltimore in general surgery.

After his postgraduate training, he returned home to Walthall County and opened a general practice of medicine and surgery in Tylertown. He eventually settled his practice in McComb with the late Dr. L. W. Brock as World War II approached. When the war came, he joined the Army's Medical Corps in 1942, serving until the war's conclusion in 1945. He spent his period of service in Europe where he would participate in the Battle of the Bulge.

His brother Wendell, 10 years his junior, had already been led into medicine by Verner, going to Ole Miss and Tulane Medical School, and he went into the military as well, serving at Okinawa and in the South Pacific. Early in the war, Verner discussed specialty training with his brother. The specialty of Eye, Ear, Nose and Throat was just separating into two specialties, "Eye," and "Ear, Nose, and Throat." The brothers decided after the war to enter the first class at Tulane and Charity Hospital in the specialties as separate entities. Verner studied "Ear Nose and Throat," or otolaryngology, and Wendell studied "Eye," or ophthalmology.

At the end of the war, Verner married Emma Dunbar Bauer (born 1919), the daughter Dr. Henry Louis and Adella Norgess Bauer of McComb on October 31, 1945. (Dr. Bauer had been an early EENT physician in McComb.) Verner and Emma had a family of two children, adopting both a daughter, Mary Melissa "Lissa" Holmes (born 1953) and a son, Verner Smith "Vern" Holmes, Jr. (born 1954).

Friend Dr. David Sansing remembers Emma as a "gracious, charming, giving, sharing, self-effacing person." He remembered her sublimating herself for Verner's

career, caring for the children and the home with a vigor that created a strong family unit. "He didn't have to turn the shower on at home," Sansing recalls. "She adored him."

Emma would die in 1986 of cancer. Verner later married Mary Williams, the mother of well-known actress and former Miss America Mary Ann Mobley. In recent years, he and his wife Mary lived in retirement in Jackson, but maintained contacts with family and friends in McComb.

After finishing their specialty training at Tulane, the brothers looked to McComb as their place of practice. Dr. Willis Cotton had been an early EENT doctor there and the Holmes brothers bought out his practice after his death. From 1948 to 1968 the brothers operated The Holmes Eye, Ear, Nose, and Throat Clinic and Hospital, located at 210 North Front Street behind the old McComb Post Office. The hospital the Holmes brothers ran was a small one, with six to eight beds, with usually brief hospital stays. But despite its size, it was an approved and accredited hospital. The hospital would close with the opening of Southwest Mississippi Regional Medical Center in 1969, but their clinic practice would continue, and brother Wendell remains in the practice of Ophthalmology.

In middle life, Verner, having grown up on a farm, was looking for a place to relax and a recreation camp or farm for his family. He happened to find the old Quin place on Highway 44 at Quin's Bridge at the Bogue Chitto River. Here he would build a pecky cypress river house, which would achieve fame as the writing place of his friend, the acclaimed writer Willie Morris.

His Ackerman college friend Plemon Coleman, who was the Attorney General of the state in 1954, found his old college friend Verner Holmes building his river house on the Bogue Chitto at that time. Coleman came up from his car and asked his friend, who had hammer in hand atop the roof, "Verner, I am running for Governor." To this, Verner responded, "J. P. What can I do?" Thus began Verner's two and a half decades of public service in Mississippi.

Verner was a critical player in the Coleman campaign. But early on, on the night of the first primary, Coleman's outlook was grim. He did not appear to be one of the two finalists as the votes were coming in. Verner encouraged Coleman and told him not to give up, to "wait until all the rural votes are counted." Holmes's advise was right and Coleman edged out Fielding Wright, Ross Barnett, and Mary Cain to get into the second Democratic primary of 1955. He then handily beat Paul Johnson Jr. in the runoff to be elected Governor.

Holmes was appointed chief of staff of Coleman's Colonels, the first physician selected as chief of staff by a Mississippi Governor. This honorary staff delegation dressed historically in military style uniforms. In typical Holmes modesty, he changed the attire of the Colonels. He told Coleman "I'll be glad to be chief of staff of the Colonels, but I don't want to wear the uniforms. They look like a high school band." The two made history by changing the attire of the Colonels to blue blazers and gray trousers.

In 1956, Coleman had to make a special appointment to the Board of Trustees of the Institutions of Higher Learning, better known as the College Board. The board controlled all of the public colleges and higher educational offerings in the state. This was a special appointment to give the new four-year medical school a voice on the board. When Coleman called him up to serve on the board, Holmes asked him "What is that board?" Coleman then explained that while the board was not highly visible, he considered it perhaps the most important appointment in state government. Coleman stated, "I want a doctor on that board to oversee the medical school."

Holmes would chair the Board Committee on Medical Affairs for the next twenty-four years. Of these two 12-year terms, Ole Miss historian David Sansing called the service "unique." "No one has ever served that long," he explained.

In his appointment, he led the board's work with the University Medical Center. As its faculty was being selected, many of the local Jackson physicians were seeking appointments as faculty members. Holmes strongly recommended that faculty be sought from academic medical centers rather than from local physicians. Sansing relates, "One of Verner Holmes's great achievements was the University's status as a freestanding institution not dominated, controlled or staffed by local politics." Sansing states further, "Verner's enduring legacy is the integrity of that medical school."

When Coleman was Governor, a crisis occurred in 1957 regarding the building of the new VA Hospital on Woodrow Wilson Drive in Jackson. In order for Coleman to get VA approval, he had to give the land for the hospital to the U. S. government from the state, and in doing so sign a declaration that the institution would be desegregated according to federal laws. Coleman told historian Sansing,

"That was the hardest decision I ever made but the best decision I ever made." Coleman knew thousands of vets needed the care the hospital would offer. He called Verner and asked what he should do. Verner said, "Sign it!" and with this encouragement, Coleman signed the declaration and now the VA Hospital is one of Coleman's monuments and one of the proudest moments in his administration.

Sansing states, "Their relationship (Coleman and Holmes) was more than a political or advisory relationship. Their relationship went back decades, and they admired, respected, and liked each other. They shared ambition, integrity, courage, and a will to succeed."

In 1962, in the midst of the James Meredith integration crisis at Ole Miss, Holmes publicly opposed Governor Ross Barnett in his attempt to block Meredith's admission. As the governor was stating his plan to close the university rather than let a black enroll, Holmes, vice-president of the College Board, stated he would not vote to close Ole Miss.

After the VA controversy and the Meredith crisis at Ole Miss, Holmes as a member of the College Board gave orders to quietly desegregate the University Medical Center. In the middle of the night, the Medical School Dean Robert Marston removed the "Colored" and "White" signs at the entrances to the hospital. He also led the integration of the medical school with the first black student enrolling in 1966. All of this was done without fanfare and event, due to the calm and reasoned leadership of Holmes, who assumed personal responsibility for the actions.

In the midst of the Civil Rights Era, Sansing recalls that a cross was burned in Dr. Holmes's yard in McComb. The FBI came down and told him that they knew who the cross burner was. "I don't want to know," he told them. "Someday this person or his wife or children may come out to my medical clinic. I want to be able to follow my calling without feeling influenced negatively by this." This is how important Holmes considered his duties as a physician, says Sansing.

Holmes once told Sansing that the College Board job "cost him money," eating up a lot of time and effort: it usually took him away from 5 to 6 days of office practice a month. Brother Wendell helped Verner at their joint practice during his service on the College Board. Dr. Wendell remembers doing emergency ENT surgery in his



Verner S. Holmes, M.D. (1909-2000)



*Dr. Verner S. Holmes (1909-2000) stands in front of the mantle inside his Jackson home last Spring. The *Magnolia Gazette*, of which the **JOURNAL MSMA** Associate Editor Lucius Lampton, M.D. is Editor-in-Chief, was blessed to spend some time with Dr. Holmes and his lovely wife, Mary, last year in preparation of an article on his contributions to health. Dr. Holmes, 90, was buried in McComb's historic Hollywood Cemetery. In this article Dr. Lampton surveys his life and contributions to Mississippi medicine and higher education. Photo by Kim Harris*

brother's absence at board meetings. But he remembers Verner enjoyed his time on the College Board a great deal. Verner also retained his great modesty about his accomplishments, once telling Sansing: "Over the years, I have gotten a lot of credit. I never deserved it. I only did the right thing."

"I think his 24 years was the most productive public service of anyone that I know," Sansing said. "He honored that public trust with a fidelity rare in Mississippi."

Ole Miss Chancellor Robert Khayat remembers Dr. Holmes as a "truly remarkable person. In his profession, through his service to higher education and in his community, he worked tirelessly and thoughtfully to enhance the quality of life for all Mississippians. He will be remembered for his contributions and for his gentle touch."

One of the facilities on the University Medical Center campus in Jackson bears his name, the Verner S. Holmes Learning Resource Center, named for him in

1982. It symbolizes his great dedication to the success of that institution and includes a huge portrait of him in its main foyer. "The Medical Center will always be in Verner's debt because he always looked out for the Medical Center's interests during a time when the leaders of the state had to be guided in the unique needs of health professional education," said UMC Vice Chancellor Dr. Wallace Conerly.

Dr. Norman Nelson, the retired vice chancellor for Health Affairs at the Medical Center once said of him, "I wish there were some magic formula by which we could put his faithfulness to the health of the community into a capsule and insist that all our students take it. His life vividly demonstrates what we can never teach: that the profession of medicine requires we know and love people as much as we know and love science — and that our best leaders are our most willing servants."

Dr. Holmes was chairman of the state's first Com-

prehensive Health Planning Advisory Council and was instrumental in locating the nursing training program at Southwest Mississippi Community College.

He pushed for the creation of Southwest Mississippi Regional Medical Center for years, trying to get the McComb Hospital and the McComb Infirmary to support the idea. With Dr. Ralph Brock and attorney Norman Gillis, Holmes was one of the leaders who made SMRMC become a reality. He would serve as the first chief of staff at the new hospital. He reflected, "How often it seemed that we would never be able to have this remarkable hospital at all. Often it appeared that all the effort and energy, all the meetings and conferences, all the letters written and calls made would be of no avail. There is no way to know of all the hard work done by so many people involved in laying the groundwork for what we see today—a great institution serving the health needs of the area."

He was a past president of the Mississippi Eye, Ear, Nose and Throat Association. He received the Mississippi State Medical Association's A. H. Robbins Award for Community Service in 1978. He was a lifelong member and past president of the McComb Rotary Club. He had perfect attendance for over 35 years. He had been a longtime member of J.J. White Memorial Presbyterian Church and was a member of the First Presbyterian Church of Jackson.

In 1978, Ole Miss Chancellor Porter Fortune asked Ole Miss history professor Dr. David Sansing to assist Holmes in the completion of his memoirs. The two met in Biloxi in June of 1978. "I never called him Verner. Only Dr. Holmes. I simply had too much regard for him not to call him that," said Sansing.

At this first meeting, Sansing remembers that Holmes was angry that the College Board had refused to approve a resolution giving Jackson State University the authority to build a decorative garden in honor of a former JSU president. He felt strongly that the board should have approved it and commented that if Ole Miss or Mississippi State had presented similar proposals, they would have been approved.

"He was no liberal and no radical, but he believed in fairness, honesty, and integrity," said Sansing. Holmes once told Sansing, "My father never let us use the term 'nigger.' If we used it, he would wear us out. He taught us to respect men for their individual worth and nothing else."

The deeper Holmes and Sansing got into his "memoirs," the more Holmes began to direct the project away from himself and towards the broader perspective of the College Board and higher education in Mississippi. Over time the project became the book *Making Haste Slowly*:



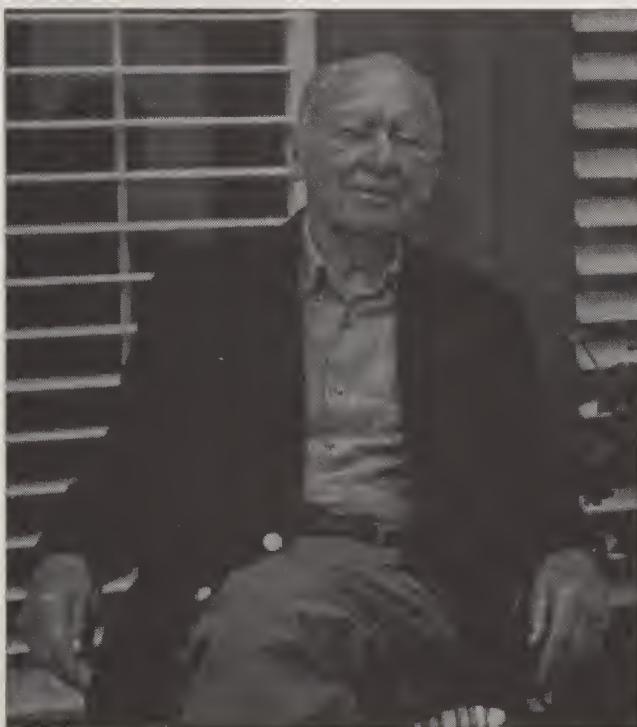
Dr. Verner Holmes shown here at his Jackson house with his wife, Mary, last spring. Holmes died May 21, 2000. Photo by Kim Harris



Verner Holmes hugs Mary as they enjoy a spring day in Jackson last year at their residence. Photo by Kim Harris

The Troubled History of Higher Education in Mississippi (1990), which Sansing dedicated to Holmes and his first wife Emma.

During the 1980s, mutual friend Sansing introduced Ole Miss writer-in-residence Willie Morris and Holmes,



Dr. Verner S. Holmes (1909-2000)—the native of Old Pike County and longtime McComb ENT physician left an enduring legacy in medicine and higher education in Mississippi. He is the only Mississippian to serve two twelve year terms on the State's College Board. Photo by Kim Harris

and the two became close friends (That relationship is described in detail in the October 1999 *JMSMA*). After several years, Morris told Dr. Holmes that he would be leaving Ole Miss to work on a novel. Holmes invited him to live and write at his house located on the Bogue Chitto River. (This same house was featured in WTBS's *Portrait of America* series). Willie came down and wrote for almost 3 years on the banks of the river. Morris became very close to Holmes's son Vern, as well. Morris dedicated his collection of essays entitled *Homecomings* to "Verner Holmes of McComb and downtown Lexie," and "to Vern Holmes of the Bogue Chitto." Morris conceived and wrote *Good Old Boy and the Witch of Yazoo* in Pike County.

Holmes would take Morris on tours of the area, to Tylertown, China Grove, and back to his native Lexie and its water tower. Morris would tease Holmes of the "drawing power of the new Lexie water tower," and of the coming influx of people to the future great metropolis, all because of the grand water tower.

Last July, Verner celebrated his 90th Birthday Party, with friends hosting a grand party at the Jackson Country Club. Robert Khayat, Chancellor of Ole Miss, presented

Verner an Ole Miss Football jersey with the name Holmes and number 90 on the back. He danced and enjoyed the party a great deal.

Several months ago, Dr. Holmes experienced a stroke and worsening heart failure. He declined gradually until his death in May.

Dr. Holmes was preceded in death by his parents; his first wife, Emma Bauer Holmes; and a brother, Omer L. Holmes.

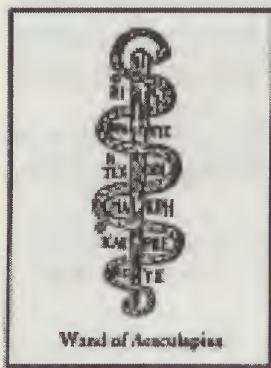
Survivors include his wife, Mary F. Holmes of Jackson; one son, Verner S. Holmes Jr. of Ridgeland; one daughter and son-in-law, Lissa and Jim Covington of McComb; one granddaughter, Lyn Covington, a student at The University of Mississippi; one stepdaughter, Mary Ann Mobley Collins; one step granddaughter, Clancy Collins of Beverly Hills, Calif.; one brother, Dr. Wendell B. Holmes of McComb; and two sisters, Iska Holmes Montgomery of Lexie and Willette Holmes Lancaster of Pensacola, Fla.

Pallbearers were Dr. Will Austin, Bradford J. Dye, Dr. Ford Dye, Dr. Lewis Guy, Bobby Brock, Dr. Robert Khayat, Dr. Wallace Conerly, Dr. Jim Hughes, Dr. Mark Meeks and Charlie Jacobs. Honorary pallbearers were Dr. Norman Nelson, Dr. Arthur Guyton, Dr. James Hardy, Charles Ed Harper, Prescott Sherman, Tally Riddell, Bobby Chain, Henry Hederman, Dr. David Sansing, John L. Black, Dick Degler, Altus Holmes, Waldo Hitt, Newton James, Dr. Tom Mayer, Charlie Dunagin, Billy Neville, Warner Alford and John Ruppert Lovelace.

The family asks that memorials be made to the Verner S. Holmes Learning Resource Center at the University Medical Center, in care of the Division of Public Affairs, 2500 N. State St., Jackson, MS 39216-4505, or to the J.J. White Memorial Presbyterian Church in McComb.

—Lucius Lampton, M.D.
Associate Editor

The writer would like to thank Dr. Wendell Holmes of McComb and Dr. David Sansing of Oxford for their assistance with this article. Dr. Sansing, when interviewed, was headed to Gettysburg, PA, for the dedication of a monument to the University Greys Confederate brigade, who, 137 years after the battle, had their courageous sacrifice (I believe over 80% mortality) recognized. I also want to thank Janis Quinn and others at UMC Public Affairs, and the staffs of the *Magnolia Gazette* and McComb's *Enterprise-Journal*.



Looking Back: Brass Pin Into Wharton's Duct

Selected and edited by Lucius Lampton, MD, Associate Editor

[“Looking Back” will be a monthly feature of the Journal. This editor will select interesting articles published in past issues of the Journal of the Mississippi State Medical Association, the Mississippi Doctor, and the Transactions of the Mississippi State Medical Association. Any doctors with old volumes of these publications are invited to submit articles from them for publication in “Looking Back.” We hope our readers will enjoy this new feature.

This month we look back to the Transactions of the Mississippi State Medical Association at the Twenty-first Annual Session, held at Jackson, on April 18 and 19, 1888. Mississippi physician W. E. Herring, M. D. of Terry presented this paper at that meeting.

For those of you perhaps slightly rusty on your gross anatomy, Wharton's Duct, also *ductus submandibularis*, is the duct that drains the submandibular gland and opens at the sublingual caruncle. This submandibular duct is named for Thomas Wharton (1614-1673), the English physician and anatomist. As well, for the non-surgeons, a *bistoury* is a long, narrow surgical knife, straight or curved, used for opening sinuses or incising abscesses. And a *tenaculum* is a hook-like instrument for seizing and holding parts.] — Ed.

Brass Pin Into Wharton's Duct

In attempting to present a report of this little accident, I must say I am led to believe it is of very rare occurrence. Indeed, in my limited survey of the field of surgical literature I do not call to mind a similar case. We cannot but wonder, however, that it does not occur more frequently, when we see the mouth (especially of women) the receptacle of pins and other things that might as easily produce trouble. On the 15th of December last a case came under my observation of a colored woman who reported that five days previously she had gotten a brass pin in her throat; said she had consulted two physicians, one of whom failed to discover the pin; the other did, but said that he had not suitable instruments for its extraction. After protracted search and careful manipulation I succeeded in finding it. Its presence could only be recognized with difficulty, as the tissue overlying the course of the duct was greatly swollen, and intensely tender. On pressing the tongue to one side to give me a better view of the situation of things, my attention was drawn to a slit near the phraenum Linguae, which I recognized as the terminus of the right duct, and on exploration with a delicate probe had no difficulty in reaching the offending body. Next attempted to seize its point with a dressing forceps, and extract it backwards, but finding relief impracticable by that means I resorted to the following methods:

Depressed its point with some force so as to elevate the head, then by the aid of a delicate Kun tenaculum caught the pin just below its head, including as little flesh as possible, pulling the head forward until it created considerable tension of tissue above it, then with a long straight bistoury, freed the head and with the dressing forceps completed the

— W. E. Herring, M. D., Terry
Transactions, 1888, pages 99-100

Information and Quality Healthcare- The Payment Error Prevention Program (PEPP)

The Payment Error Prevention Program (PEPP) represents a new effort initiated in I.Q.H.'s Sixth Scope of Work efforts, which began last August. Now ready to close its first year, this program has been presented throughout the state and received with cooperation and collaboration as participants have realized the importance of the program and noted that the I.Q.H. approach is through a quality improvement method rather than a more punitive individual case review.

The program was designed following an audit of HCFA's 1996 and 1997 financial statements which estimated that Medicare paid approximately \$4 billion incorrectly in payments for inpatient hospital services each year.

I.Q.H. and fellow PROs throughout the country, through this new effort, were given the responsibility of reducing this inpatient error rate through PEPP, which involves analysis of paid claims data to identify patterns of potential errors where improvement may be warranted. The next step is then working with providers to implement interventions to prevent future errors.

An advisory committee of representatives from the Mississippi Hospital Association, the Mississippi State Medical Association, and the Mississippi Health Information Management Association has already contributed a great deal to the Mississippi endeavors in the first year.

Dr. Ralph Dunn is serving as the medical director for PEPP.

PEPP's Unnecessary Admissions Project

The Admission Project, required for the first year of the HCFA PEPP contract, began in August 1999. Analysis was performed on one-day stays, with 13 hospitals exceeding 2.5 standard deviations from the norm. With input from the advisory committee, this project began with record requests for review and baseline determinations.

Approximately 100 records were obtained from each of the hospitals for a total of 1313 records. Medical records came from Medicare-paid claims for the year 1998.

Hospital responsibilities in the effort to improve the appropriateness of one-day admissions include: educating staff and determining appropriate strategies to improve unnecessary admission rates; submitting an improvement plan to I.Q.H. addressing unnecessary one-day admissions; performing internal monitoring; and submitting monthly Medicare discharge lists to I.Q.H.

Remeasurement will begin in the fall, with remeasurement and analysis reports to be sent to the hospitals on a monthly basis. Final analysis will be distributed during the first quarter of 2001. Aggregate statewide data for one-day admissions revealed findings of 65.65% admissions incorrect and 34.35% admissions correct.

PEPP DRG Report Released to Hospitals

I.Q.H. earlier this year issued a report on a project concerning identification of inappropriately coded DRGs. Mailed to Mississippi hospitals in late February, the 20-page report shows the results of the statewide DRG project.

The initial DRG project included five DRGs identified through analysis of 1998 Medicare-paid claims data that represented a potential for inappropriate coding. They included: 079-Respiratory Infections and Inflammations, 096-Bronchitis and Asthma, 140-Angina Pectoris, 182-Esophagitis, Gastroenteritis and Miscellaneous Digestive Disorders, and 416-Septicemia. To verify whether a statewide pattern existed that needed focused educational efforts, I.Q.H. obtained a statewide random sample of 100 records assigned to each of these DRGs.

In addition to the statewide DRG project, statistical analysis of DRGs 079 and 416 was completed to identify hospitals that vary from the statewide norm by having an atypically high ratio of discharge rates. Records from hospitals that fell into this category were requested for data collection. Results of data collection for the DRG 079 project were mailed to individual hospitals the first week of May. Data collection for the DRG 416 project is in progress and will be mailed at a later date.

HCFA Baseline Determination

The records selected by HCFA for determining the PEPP baseline error rate and for remeasurement are screened by the clinical data abstraction center (CDAC). Any record failing the screen is sent to I.Q.H. to go through a case review process. If, after physician review, a potential concern is found, an opportunity to respond is offered to the provider or attending physician. The review could result in denial of payment or adjustment in the DRG for the reviewed records. These records are separate from those selected by the PRO for PEPP data collection for improvement projects.

PEPP Compliance Workshops Offer Assistance

Hospital representatives throughout the state have participated in several workshops planned in order to assist hospitals in meeting the goals of the Payment Error Prevention Program through the development of a hospital compliance program.

The various presentations have been designed to provide specific guidance in areas more commonly associated with payment errors such as coding, utilization management, and documentation. Also offered was specific guidance for performing coding and claims audits to monitor compliance program effectiveness and to provide

useful tools for development, maintenance, and evaluation of compliance programs.

New Board Members Welcomed

Physicians elected to serve on the I.Q.H. Board of Directors for three-year terms include: Virginia Crawford, Hattiesburg; Richard deShazo, Jackson; Tom Jeffcoat, McComb; Keith Mansel, Oxford; Glen Peters, Louisville; one-year terms: David Hall, Natchez, and Lucius Lampton, Magnolia. Dr. Hursie J. Davis-Sullivan is also serving on the board for the next year, appointed for an unexpired term. Newly appointed hospital representatives on the board are Linda Gholston of Grenada Lake Medical Center and Jack Cleary of River Oaks Hospital.

Physicians recognized for their contributions and service these past years were: Rodney Frothingham of Greenville, John Patterson of Pontotoc, John Cook of Jackson, Charles Brock of Cleveland, Leonard Brandon of Starkville, Kenneth Reid of Meridian, and Leslie England of Natchez. Hospital representatives retiring from the board are John Dawson of North Mississippi Medical Center in Tupelo and William Oliver of Forrest General Hospital in Hattiesburg.

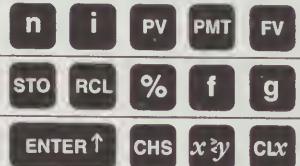
—James S. McIlwain, MD, President

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Cover photo: Bruce Sabatino, M.D. is a board-certified emergency medicine physician. He has practiced in Meridian, Natchez, and Amory Mississippi. He and his family live in Meridian. Dr. Sabatino took this photograph of a print on display at the Delta Blues Festival, Greenville, Mississippi, September 1998. The original painting was by artist William Tolliver of Tolliver Fine Art, Inc., Stone Mountain, Georgia. Tolliver was also selected to produce a poster for the 1996 Olympic Games held in Atlanta.

The Delta Blues Festival traditionally takes place the third Saturday in September, this year the 17th. For more information on the festival contact the Washington County Convention and Visitors Bureau, 1-800-467-3582.

Off-Pump Coronary Artery Bypass (OPCAB) in Southern Mississippi

F. Clark Sauls, M.D.
David B. Stephens, M.D.
Regina Caveny, Ph.D.

A bstract

Off-Pump Coronary Artery Bypass (OPCAB) allows myocardial revascularization without use of cardiopulmonary bypass and may be associated with fewer postoperative complications. A retrospective review was undertaken to assess the value of this new strategy in our surgical practice. The records of all our patients (n=259) undergoing isolated coronary artery bypass (CAB) operations from January 1 through December 31, 1999, were reviewed (Table 1). Patient characteristics and comorbidities were similar in both groups with the exception of age and diabetes (Table 2). Mean operating room time, blood products transfused, morbidity, mortality, and length of stay (LOS) were all significantly less in the OPCAB group. We conclude that OPCAB techniques may offer significant benefits to our population of patients undergoing myocardial revascularization.

Introduction

Newer approaches to minimally invasive cardiac surgery include the strategy of off-pump coronary artery bypass (OPCAB). This technique allows for multi-vessel coronary revascularization via a median sternotomy incision without use of cardiopulmonary bypass, crossclamp, or cardioplegia. It is thought that much of the morbidity of bypass surgery may be related to the "pump" and its attendant pathophysiology. Cellular activation, cytokine responses, and activation of the complement system have all been described in this regard.^{10-12,14} Use of OPCAB methods, therefore, might allow patients to avoid some of the serious morbidity of CAB surgery.

Table 1. Study Group

	CPB	OPCAB	TOTAL
FCS	54	71	126
DBS	90	44	135
TOTAL(%)	144(55.6)	115(44.4)	259(100)

Since the recent introduction of effective tissue stabilization systems², OPCAB technology has been evolving rapidly and growing in popularity. In our own practice, the first OPCAB cases utilizing this new instrumentation were done in late 1997. These initial efforts were limited to grafting of single vessels on the anterior cardiac wall. In early 1999, we began using this strategy more frequently for more high-risk patients and for multi-vessel grafting. We formed a strong clinical impression that our OPCAB patients were experiencing much better outcomes. Because of this, we decided to review all our CAB patients operated on in calendar year 1999 to assess the value of this method in our practice.

Methods

A retrospective chart review of all 259 patients having isolated CAB operations by the authors from January 1, 1999, through December 31, 1999, was performed. From each record were abstracted age, gender, weight, height, comorbidities, left ventricular ejection fraction and end-diastolic pressure, details of the patient's operative procedure, preoperative hemoglobin and hematocrit, postoperative hemoglobin and

Table 2. Patient Characteristics

	CPB	OPCAB	
Age (Years)	63	59.9	P=0.046
BMI	28.3	28.1	NS
Male/Female(%)	72.9/27.1	67.5/32.5	NS
Emergency(%)	15(10.4)	7(6)	
Diabetes(%)	35	23	P=0.047
Hypertension(%)	64	60	NS
Recent MI(%)	31	31	NS
IABP(%)	10	8	NS
COPD(%)	17	21	NS
PVD(%)	14	14	NS
CVI(%)	10	16	NS
REDO(%)	4	6	NS

Table 3. Operating Room Experience

	CPB	OPCAB	
Time (Minutes)	234	180	P=0.0000
Number Grafts	3.5	2.6	
Minutes/Graft	72.8	77.1	
CPB Time (Minutes)	110		
Clamp Time (Minutes)	55		

CPK-MB, blood product use, details of the postoperative course, and length of stay (LOS). Cases were divided into an on-pump (CPB) group (144 patients, 55.6% of the total) or an off-pump (OPCAB) group (115 patients, 44.4%) depending on whether cardiopulmonary bypass (CPB) had been utilized in the course of their operation. The CPB group included 12 conversion cases (9%) that required CPB for successful completion of their operations.

All operations were done under general anesthesia with invasive monitoring including arterial line, Swan-Ganz and Foley catheters. Inotropic, pressor, and antiarrhythmic drugs were given as indicated under the direction of the anesthesiologist.

Cases done on cardiopulmonary bypass were cannulated in the ascending aorta and right atrium. Antegrade cold blood cardioplegia was utilized in each case, and retrograde cardioplegia was used selectively. Temperature on bypass was maintained at 28-30 degrees Celsius, and the Activated Clotting Time (ACT) was maintained greater than 480 seconds. Left ventricular venting via the right superior pulmonary vein was practiced routinely. Temporary pacing wires were placed routinely in all these cases. Generally, distal anastomoses were done first under cardioplegic arrest while proximal anastomoses

were done with the use of a partial-occluding clamp during rewarming. Mean cardiopulmonary bypass time for these cases was 110 minutes and mean crossclamp time was 55 minutes.

For OPCAB cases, attempts were made to maintain core body temperature greater than 34 degrees Celsius. As a routine, the proximal anastomoses were done initially, and the ACT was maintained greater than 200-250 seconds until grafting was completed. Reversal with protamine was accomplished with 100 mg or less in every case. The Octopus, Octopus II, or Octopus II+ (Medtronic) tissue stabilization system was used in every case. A mister/blower was also used in each case. Appropriately sized intraluminal shunts ("Flowcoil", CTS) were used in most cases. Temporary pacing wires were not routinely used for these cases.

Results

The characteristics of the patients in the CPB and OPCAB groups are given in Table 2. We noted a high prevalence of

diabetes mellitus (DM), recent myocardial infarction (RECM), and chronic obstructive pulmonary disease (COPD) in both groups. In addition, 8-10% of these patients came to us from the cardiac catheterization laboratory with an intra-aortic balloon pump (IABP) already in place.

Time in the operating room (OR) was significantly less for the OPCAB group, and patients in this group received fewer grafts on average (Table 3). Each patient in the CPB group had as many as six grafts or up to five in the OPCAB group. When the time in the OR was divided by the number of grafts (Min/graft) and averaged for each group, findings were similar. Types of grafts and their distribution to the various coronary tributaries are depicted in Figures 1-3.

Preoperative hemoglobin concentrations were the same for both groups. Postoperative hemoglobin was significantly higher for the OPCAB group (Table 4). Also, the total number of units of packed red cells, fresh frozen plasma, and platelets used was much lower for the OPCAB group.

Mean postoperative CPK-MB levels were significantly lower for the OPCAB group, suggesting better myocardial protection (Figure 4). Perioperative myocardial infarction was only 1% in the OPCAB group vs 6%

in the CPB group ($P=0.016$).

Other postoperative complications were less common in the OPCAB group as well. Atrial fibrillation, for example, was reduced from 26% in the CPB group to 8% in the OPCAB group ($P=0.0001$, Figure 5). There were no strokes, renal failure, or sternal wound infections observed in the OPCAB group (Figure 6). The only major infection seen in this group was a case of pneumonia in a patient who smoked heavily until the time of surgery. Otherwise, respiratory complications were uncommon in the OPCAB group (Figure 7). Early reexploration for bleeding, cardiac tamponade, or cardiac arrest was required in 5% of the CPB group but for only 1% of the OPCAB group ($P=0.047$). Thirty day mortality was 7% in the CPB group vs 2% in the OPCAB group ($P=0.035$).

Finally, while preoperative LOS was not significantly different between the two groups, average postoperative LOS was 2 days less in the OPCAB group ($P=0.0000$, Figure 8). Average hospital charges for the CPB group were \$38,747.37 and \$35028.55 for the OPCAB group. This difference, \$3,718.82, represents a 9.6% reduction in hospital charges.

Discussion

Our impressions concerning more favorable clinical outcomes for OPCAB patients were confirmed by this review. This study suffers the scientific weaknesses of being retrospective, nonrandomized and unblinded. However, prospective randomized studies would not be practical in our rural heart program. A retrospective review such as this is more in keeping with our capabilities and may still be helpful in confirming clinical impressions.

Kolessov reported the first CAB procedure without CPB in 1967¹. From that time until recently, however, the number of such cases was small and anecdotal. In May, 1996, Borst and colleagues reported laboratory use of a new tissue stabilization device known as the "Octopus"². After further refinement, this system was brought to market in the United States for clinical use by Medtronic in 1997. Since then, the advent of other competing tissue stabilizers and other adjunctive technology has helped to fuel the growing popularity of this approach to CAB³⁻⁵. Other reported series of cases suggest the safety and effectiveness of this method⁶⁻⁹.

The generalized inflammatory response characteristic of surgery involving CPB is greatly attenuated for MIDCAB and OPCAB patients. Whether this attenuation can be the sole explanation for the observed reduction in morbidity and mortality is not known^{11,12,14}. However, many presently believe it to be the main reason for improved outcomes in patients revascularized off-pump.

Figure 1. Distribution of Target Vessels

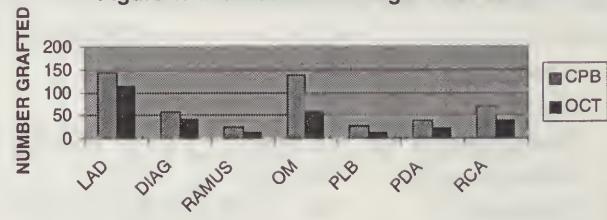


Figure 2. CPB Group Grafts (n=500 grafts)

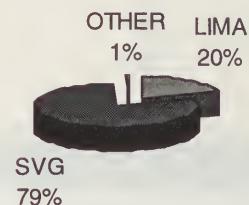


Figure 3. OPCAB Group Grafts (n=297 grafts)

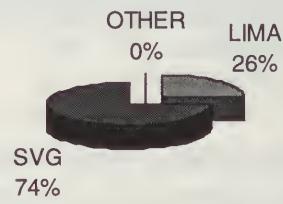


Table 4. Blood Loss And Transfusion Requirements

	CPB	OPCAB	
Hemoglobin (Gm/dl)			
Preoperative	13.6	13.6	NS
Postoperative	10.4	11.2	
Average Drop	3.2	2.3	$P=0.0004$
Units Transfused			
Packed Red Cells	340	92	
Fresh Frozen Plasma	49	6	
Platelets	191	1	

Recent reports suggest that the OPCAB technique affords better myocardial protection^{14,15}. Only minor changes in myocardial metabolism are observed in these patients¹³. One author noted a correlation between troponin-I levels and Interleukin-8 (IL-8) and suggested that the blunted cytokine response reduces myocardial injury. Mohr, et al¹⁵, concluded that this approach is relatively

Figure 4. Postop CPK-MB

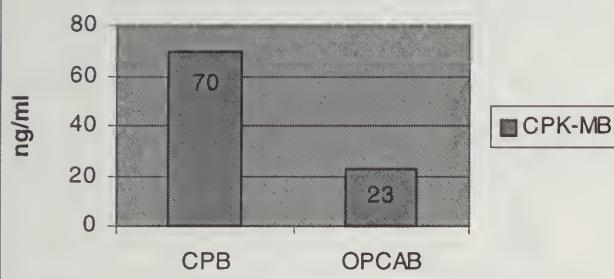


Figure 5. New-Onset Postoperative Atrial Fibrillation

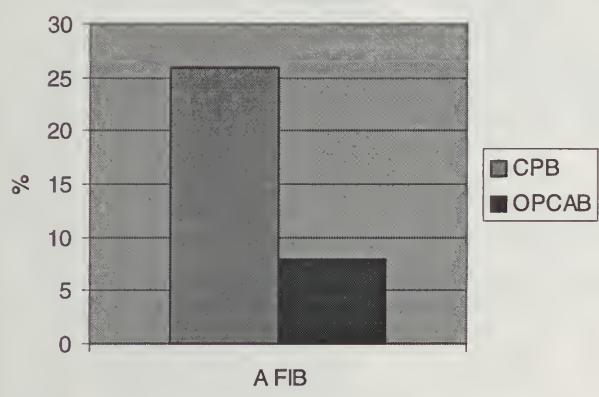


Figure 6. Postoperative Complications-I

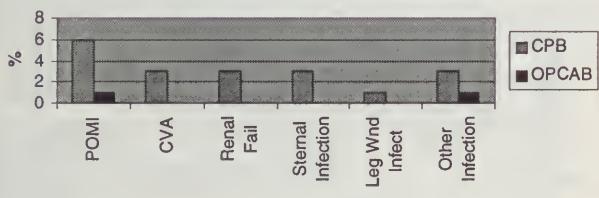
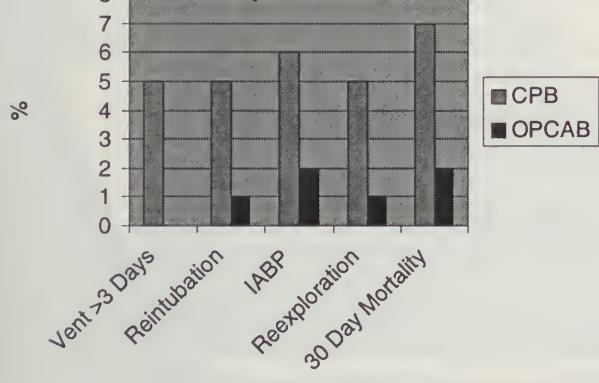


Figure 7. Postoperative Complications-II



safe for patients with recent myocardial infarction (MI). Of our patients, 31% had recent MI's, and we think our results agree with that conclusion. Our findings of significantly fewer perioperative MI's and lower CPK-MB levels are also in agreement.

Off-pump approaches also appear to offer better protection of the central nervous system (CNS) during CAB surgery¹⁶⁻²⁰. S100B, a protein released from astroglial and Schwann cells, has been measured by several groups after CAB surgery¹⁶⁻¹⁸. These studies have suggested that aortic cannulation is a high-risk time period for cerebral injury due to embolization. Anderson, et al¹⁸, studied this release in three populations of CAB patients. There was a 10-fold greater increase in S100B after CPB cases as opposed to off-pump methods. S100B release after OPCAB was only slightly greater than that seen with MIDCAB. Murkin, et al¹⁹, demonstrated less postoperative cognitive dysfunction after OPCAB compared to CPB cases. BhaskerRao, et al²⁰, also found less cerebral dysfunction postoperatively in their OPCAB patients using ASEM testing.

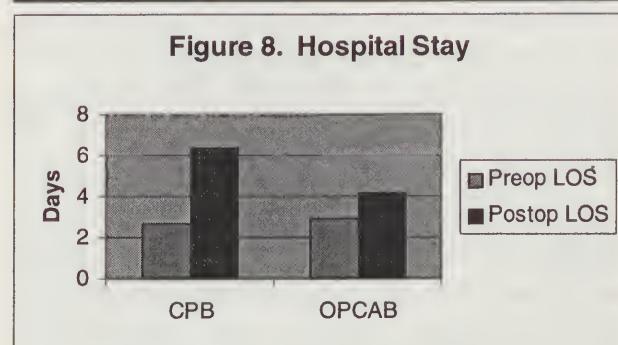
In our study, the absence of strokes in the OPCAB group is consistent with these conclusions.

Ascione, et al²¹, concluded that compared to conventional CAB with CPB, OPCAB revascularization offered superior renal protection. We agree with this conclusion noting that none of the patients in our OPCAB group experienced postoperative renal failure. We also think that the OPCAB approach is the strategy of choice wherever feasible for patients with chronic renal insufficiency, especially if dialysis-dependent.

Nader, et al²², recently compared bleeding and transfusion requirements in patients having surgery with CPB and those undergoing OPCAB. They concluded that avoiding cardiopulmonary bypass decreases perioperative bleeding and, consequently, reduces the use of bank blood products. Our experience is also most consistent with these findings. Moreover, our OPCAB patients enjoyed a significant reduction in early reexploration for bleeding or tamponade compared to the CPB patients.

Finally, it has been suggested that revascularization by OPCAB methods is less costly. Boyd, et al²⁴, found an average reduction in cost of \$1,082 (Canadian) while Ascione and colleagues²³ found an average reduction in cost of \$1,116.47 in their recent studies. Our hospital's (Forrest General Hospital, Hattiesburg, Mississippi) administration was able to supply data on hospital charges that was readily available. While charge data is in no way comparable to cost, we consider it to be a surrogate marker for cost. We found a 9.6% reduction in hospital charges for patients in the OPCAB group, suggesting

Figure 8. Hospital Stay



with others that this technique might be more cost-effective than conventional CAB with CPB.

In conclusion, we conducted a retrospective review of the CAB cases in one year, 1999, of our practice. Those patients operated on without CPB experienced fewer serious postoperative complications, less mortality, less perioperative hemoglobin drop, less exposure to bank blood products, and lower hospital charges on average. Our findings lend support to the conclusions of other investigators that OPCAB techniques afford better myocardial, neurological, and renal protection during CAB surgery than do conventional methods with CPB.

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F. Clark Sauls, M.D.

Forrest General Hospital
Hattiesburg, Mississippi 39401

David B. Stephens, M.D.

Forrest General Hospital
Hattiesburg, Mississippi 39401

Regina Caveny, Ph.D.

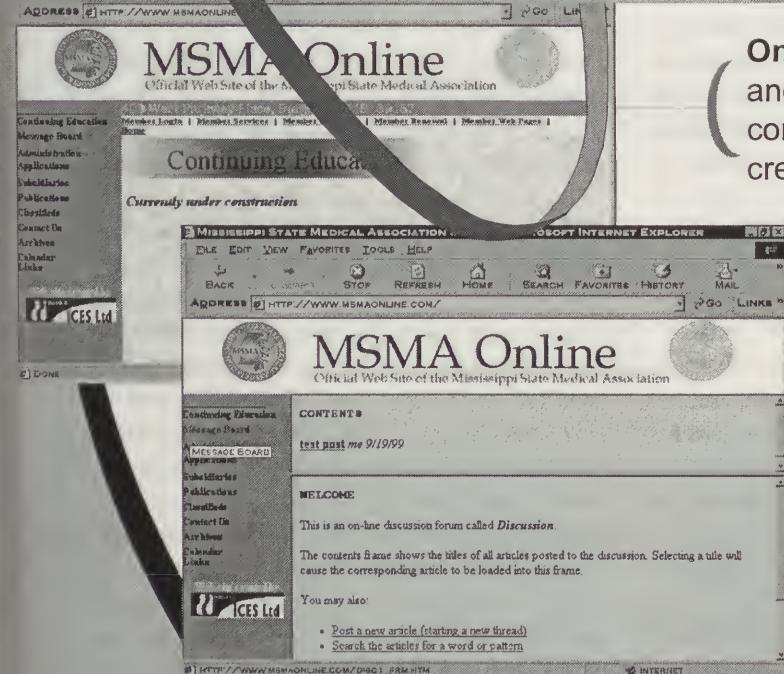
Department of Statistics
University of Southern Mississippi
Hattiesburg, Mississippi 39401
Caveny@cba.usm.edu

Reprint Requests:

F. Clark Sauls, M.D.
3403 Southaven
Hattiesburg, Mississippi
39402
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Seizures Caused by Concomitant Use of Lindane and Dextroamphetamine in a Child with Attention Deficit Hyperactivity Disorder

Robert Cox, MD, PhD
Jack Krupnick, MD
Nadine Bush, MD
Amanda Houpt

I ntroduction

Attention Deficit Hyperactivity Disorder (ADHD) is estimated to affect between 3 to 5% of the general population¹, with some studies suggesting an even higher prevalence. This disorder is commonly treated with amphetamine-type stimulant medications including methphenidate and dextroamphetamine. Scabies (*Scabies scabiei*) and lice (*Pediculus humanus*) are also common disorders, treated with topical pesticides such as lindane and permethrins. The most common serious side effect of lindane use is seizures. Amphetamines also cause seizures in overdose situations and potentially lower the seizure threshold in therapeutic doses. This report describes a child being treated with dextroamphetamine for ADHD, who experienced several seizures following the use of lindane for head lice (*Pediculus humanus capitis*).

Case Report

We report an eleven-year-old male who was treated with a 1% lindane shampoo for head lice. The parents reported that the shampoo was applied only to the scalp, but was not washed off after the ten minute period recommended for head lice. Four to five hours later the patient experienced two episodes of generalized tonic-clonic seizures over a 30-minute time span. The shampoo was washed off after the first seizure. Five other family members were treated in the same manner without adverse side effects. None of the children had a prior history of seizure

disorder. The only difference in the patient and the other children was a diagnosis of ADHD for which he had been treated with dextroamphetamine for approximately one year at a fixed dose.

On presentation to the pediatric emergency department his vitals were temperature 97.9 F, pulse 126, blood pressure 118/60, and respiration of 22. He was described as somnolent but easily arousable with episodes of agitation and irritability. No seizure or postictal activity was noted. Skin was warm and dry without rash, abrasion, erythema, or lymphadenopathy. Pupils were 5mm and reactive. Extraocular muscles were intact without nystagmus. Oropharynx and mucus membranes were moist without salivation. Cardiovascular and lung exams were normal. The abdomen was non-tender with normoactive bowel sounds. Neurologic exam demonstrated no focal findings. Initial glucose was 145 and the pulse-ox on room air was 98%.

Following his initial evaluation, he was again showered. He became more coherent over the first hour in the emergency department. There were no further episodes of seizure activity. Initial laboratory results of complete blood count, electrolytes, glucose, creatinine, arterial blood gases and urinalysis were all within normal limits. Urine drug screen was positive only for amphetamines. The lindane level twelve hours after the initial exposure was 8 ng/mL (>20 ng/mL reported as

toxic). The dextroamphetamine level was 24 ng/mL, with the therapeutic range for ADHD being 10-50 ng/mL. The patient was admitted to the PICU for observation. Further workup for the seizures included computerized tomography (CT) of the head, EEG and a lumbar puncture, all of which were normal. The patient had no more seizure activity during his hospital stay. On follow up one month later, he had no further seizure episodes and remained on the same dose of dextroamphetamine.

Discussion

Lindane is used medically as a scabicide, pediculicide and as a general insecticide. It is well absorbed topically through intact skin with a reported 9.3 % percutaneous absorption rate². Lindane blood levels after applying 1% lotion to infants for scabies peaked at 28 ng/mL at 6 hours and were 23 ng/mL 12 hours after the application³. Factors which affect absorption include concentration, application amount, site (topical vs oral), presence of skin defects, ambient temperature, and duration of exposure. Occlusive dressings including the effect of pillows and bed sheets increase absorption. Breaks in the dermal surface such as abrasions also increase absorption. It is expected that there would be much greater absorption during the treatment of scabies, in which the entire body below the head is covered and the lotion is left on for 8 to 12 hours. When treating head lice, the shampoo is applied only to the scalp and left on 4 to 10 minutes. In the present case, the 1% lindane shampoo was left on the scalp longer than prescribed for head lice, but the body surface exposed and time of exposure were still considerably less than if he were treated for scabies. There was no evidence of skin breaks that may have increased absorption. The concentration of lindane in the blood was well within the range expected for therapeutic use.

Most cases of lindane induced seizures occur at very high doses or in the very young, or in those with underlying diseases like HIV infection that may lower the seizure threshold^{4,5}. Typical blood levels in patients experiencing seizures ranged from 130 ng/mL to 1300 ng/mL⁴. The patient with the lowest blood level had an underlying seizure disorder. Our patient had a level of 8 ng/mL twelve hours postexposure. This is well below the toxic range and even less than typical levels seen in patients treated with lindane for scabies. He was in the adolescent age and had no prior history of seizure activity. Five other family members were treated with lindane in an identical manner with no untoward effects. The only difference being that the child who experienced the seizures was being treated with dextroamphetamine for

ADHD.

Because lindane is very lipophilic, concentrations in the brain are higher than those found in the blood. Studies in dogs have shown 5 to 12 times higher concentrations in the brain, with the highest concentrations in the pons⁶. In one infant fatality, the brain concentrations were three times those found in the blood⁵.

Lindane is believed to cause CNS excitation and seizures by inhibition of g-aminobutyric acid (GABA). It has a stereochemical structure and activity in-vitro similar to the GABA antagonist picrotoxin. Amphetamines also lower the seizure threshold and appear to antagonize GABA. Single doses of dextroamphetamine have been shown to decrease the latency to generalized motor seizures produced by the GABA antagonist picrotoxin⁷ and may directly decrease GABA concentrations⁸. In addition, chronic amphetamine administration also decreases the seizure threshold by stimulation of the N-methyl-D-aspartate (NMDA) receptor⁷. Thus, lindane and dextroamphetamine appear to have similar mechanisms in producing seizures by GABA antagonism or suppression and may be synergistic.

Although amphetamines are generally not recommended for those with seizure disorders, limited studies demonstrate that they may be used safely in ADHD patients with seizure disorders (8). In these situations, anticonvulsant levels must be monitored very closely. Although a single case report is not proof that lindane and dextroamphetamine are dangerous in combination, much safer agents are available for the treatment of lice and scabies. Permethrins have been shown to have equal or greater efficacy compared to lindane for treating scabies⁹. It is recommended that permethrins be used to treat lice and scabies in patients that are currently on amphetamines.

CONCLUSIONS

Our patient had been treated on a constant dose of dextroamphetamine for over one year and tolerated it well. He had no prior history of seizure disorder. He suffered two generalized tonic-clonic seizures after treatment with 1% lindane lotion for head lice. A subsequent seizure work-up was negative. He has since been maintained on dextroamphetamine with no further seizure activity. The seizures likely resulted from GABA antagonism produced independently by both lindane and dextroamphetamine. Since ADHD is a common affliction of children, and since the treatments of choice are amphetamine-type drugs it is recommended that if these patients also need treatment for scabies or lice, that permethrins be considered as the first line agent.

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Robert Cox, MD, PhD

Associate Professor

Director, Medical Toxicology Service

Department of Emergency Medicine

University of Mississippi Medical Center

Jack Krupnick, MD

Staff Emergency Physician

Memorial Mission Hospital

Ashville, North Carolina

Nadine Bush, MD

Resident

Department of Internal Medicine

University of Mississippi Medical Center

Amanda Houpt

Medical Student

Reprint Requests to: Robert Cox, MD, PhD

Department of Emergency Medicine

The University of Mississippi Medical Center

2500 North State Street

Jackson, Mississippi 39216-4505

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Further Discussion on Rethinking Medicare

[Physicians attending MSMA's 132nd Annual Session in Biloxi on May 19, 2000 will recall a lively dialogue regarding support for pursuing innovative ways Medicare recipients could select private insurance coverage with pre-tax dollars. The following report from the American Medical Association Council on Medical Service was adopted by the House of Delegates and continues this discussion. The House of Delegates also recommended for adoption Council on Medical Service Report 6 – Managed Care Organization Reimbursement Formulas, which will appear in the next *JOURNAL MSMA*] —Ed.

EXECUTIVE SUMMARY

Council on Medical Service Report 5 responds to referred Resolution 105 (I-99), which calls on the AMA to expand Policy H-165.920 by supporting mechanisms to ensure that all individuals have health expense coverage through: (1) requiring all Americans to own a minimum level of health expense coverage, and (2) creation of a health care safety net for the uninsured funded by the federal government through block grants to the states and the District of Columbia. Further, Resolution 105 (I-99) specifies that (a) such funds only be spent on indigent health care in ways determined by each state and the District of Columbia working in concert with their local government and (b) the amount of such grants be proportional to the number of eligible individuals in each such geographic area who have not received refundable federal tax credits for the purchase of individually selected and owned health expense coverage.

The attached report reviews available literature on individual mandates; discusses the advantages and disadvantages of imposing an individual mandate to purchase health insurance; and presents alternatives to an individual mandate that could be used to compel individuals to voluntarily purchase coverage. The report also discusses the merits of establishing a new program to serve as a health care safety net; describes existing safety net programs; and discusses ways to assure that the poor have access to tax credits through the establishment of mechanisms to advance credits to those who cannot afford the monthly out-of-pocket premium costs.

Despite some potential advantages, imposing an individual mandate to purchase health insurance entails serious philosophical and logistical drawbacks that can be avoided by using tax-based incentives and other non-compulsory measures to promote expanded coverage. Besides lacking political viability, an individual mandate is undesirable because it would permit the government to renege on its commitment to subsidize health insurance, and would entail an unreasonable administrative burden to enforce. Rather, with appropriately structured tax credits, virtually all individuals will face powerful incentives to obtain and maintain coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-99

Subject: Benefits and Limitations of an Individual Mandate for Individually Owned Health Insurance (Resolution 105, I-99)

Presented by: Eugene Ogród, MD, Chair

Referred to: Reference Committee A
(Susan R. Wynn, MD, Chair)

At the 1999 Interim Meeting, the House of Delegates referred Resolution 105 to the Board of Trustees. Introduced by the Colorado delegation, the resolution calls for the AMA to "expand Policy H-165.920 by supporting mechanisms to ensure that all individuals have health expense coverage through: (1) requiring all Americans to own a minimum level of health expense coverage, and (2) creation of a health care safety net for the uninsured funded by the federal government through block grants to the states and the District of Columbia requiring: (a) such funds to only be spent on indigent health care in ways determined by each state and the District of Columbia working in concert with their local governments, and (b) the amount of such grants to be proportional to the number of eligible individuals in each such geographical area who have not received refundable federal tax credits for purchase of individually selected and owned health expense coverage." The Board of Trustees referred Resolution 105 (I-99) to the Council on Medical Service for a report back to the House at the 2000 Annual Meeting.

The following report provides background on the AMA's proposal for individually selected and owned health insurance; summarizes relevant AMA policy; reviews available literature on individual mandates, including mandates for automobile insurance and mandates for health insurance in other countries; discusses the advantages and disadvantages of imposing an individual mandate to purchase health insurance; and presents alternatives to an individual mandate that could be used to compel individuals to voluntarily purchase coverage. The report also discusses the merits of establishing a new program to serve as a health care safety net; describes existing safety net programs; and discusses ways to assure that the poor have access to tax credits.

BACKGROUND

The main focus of the AMA's plan for reform of the private health insurance market, as described in Policy H-165.920 (AMA Policy Database) involves expanding patient choice of health plans by making individually selected insurance a viable alternative to employer-selected insurance. Two key recommendations of this policy are: (1) eliminating the current tax exclusion of employer-based health insurance benefits and replacing it with income-related, refundable tax credits; and (2) fostering the development of "Voluntary Choice Cooperatives" as alternative risk-pooling mechanisms that would facilitate and expand patient choice.

Recently, there has been a growing number of Congressional proposals that address the use of tax credits for the purchase of health insurance. Further, there continues to be occasional calls for a national health care system. Increased attention to health system reform has reinvigorated the debate on the possible need for an individual mandate for the purchase of health insurance. At issue is whether an individual mandate is needed to achieve health insurance coverage for all Americans and to avoid the "free-rider" and adverse selection problems under a market-based system.

Regarding a health care safety net, AMA policy on individually owned insurance would provide tax credits for everyone who purchases insurance. Therefore, the only individuals who would not receive refundable federal tax credits, and would be in need of a safety net as described in Resolution 105 (I-99), would be those who choose not to purchase health expense coverage, or those who are enrolled in a public sector health care program such as Medicare, Medicaid or the Children's Health Insurance Program (CHIP).

AMA POLICY

Individually Selected and Owned Health Insurance

At the 1996 Interim Meeting, the House of Delegates adopted policy supporting individually selected and owned health insurance as the preferred method for people to obtain health insurance coverage (Policy H-165.920[5]). To assist in the development of the policy, the Council on Medical Service undertook the development of further recommendations as to how a system of individually owned insurance should be structured.

At the 1998 Annual Meeting, the House of Delegates adopted the 17 recommendations in CMS Report 9, thereby establishing the considerable policy base that underlies the AMA's current health system reform proposal. Among the key policies established by CMS Report 9 (A-98) were the following:

- Preference for replacing the present exclusion from employees' taxable income of employer-provided health expense coverage with a tax credit for individuals equal to a percentage of the total amount spent for health expense coverage by the individual and/or his/her employer, up to a specified actuarial value or "cap" in coverage so as to discourage over-insurance (Policy H-165.920[12]).
- Preference for relating the individual tax credit for all health expense coverage expenditures by individuals and/or their employers to the individual's income, rather than being a uniform percentage of such expenditures (Policy H-165.920[13]).
- Support for strong tax incentives, such as making tax credits contingent on purchase of a specified minimum level of coverage, as opposed to compulsory approaches (Policy 165.920[14]).
- Support for unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches, religious groups, ethnic coalitions, and similar groups serving as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope (Policy H-165.882[15]).

Mandates

AMA policy favors tax incentives over compulsory approaches as a method of expanding health expense coverage (Policy H-165.920[14]). In addition, Policy H-180.978 supports expanding access to health insurance through market mechanisms rather than through government mandates and regulations. It should be noted that at the time the Council prepared CMS Report 9 (A-98), it did not recommend an individual mandate because the Council believed that a voluntary approach was preferable. Furthermore, the vast majority of state medical associations and national medical specialty societies that provided input to the Council prior to the development of CMS Report 9 (A-98) were opposed to the concept of an individual mandate.

Health Care Safety Nets

AMA policy supports the expansion of public sector safety net programs in a manner that is consistent with the goal of increasing choice through individually selected insurance. Specifically, Policy H-290.982(7) supports Medicaid and CHIP expansions, including providing Medicaid premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of tax credits; providing vouchers for recipients to use to choose their own health plans; and using Medicaid funds to purchase private health insurance coverage. The policy also supports additional funding for CHIP earmarked to enroll children to higher percentages of the poverty level. In addition, Policy H-165.871(1) states that in the absence of private sector reforms that would enable persons with low incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health care coverage to otherwise uninsured groups.

INDIVIDUAL MANDATES

Most of the literature on mandated health insurance addresses employer mandates rather than individual mandates. Aaron (1994) notes that in principle, an employer mandate is easier to administer than an individual mandate because the government need only deal with employers rather than the relatively large number of employees. On the other hand, Tobin (1994) argues that an individual mandate is preferable to an employer mandate because of the difficulties that arise in considering the unemployed, the self-employed, part-time workers, people who hold multiple jobs, and families with more than one worker working for different employers. In any case, employer mandates and individual mandates can exist simultaneously, as they do in many Western European countries.

For either type of mandate, the rationales are to: (a) achieve universal coverage; (b) avoid the “free-rider” problem, whereby care for the uninsured is ultimately paid for by the rest of society through higher taxes and higher premiums; and (c) avoid adverse selection, whereby low-risk individuals opt out of insurance, driving up costs and premiums for those who are insured.

Individual Mandates for Automobile Insurance

Over half of all states have an individual mandate for some form of automobile insurance, and other states have some form of financial responsibility law, though typically with very low liability limits (Smith and Wright 1992). In practice, there are substantial numbers of uninsured drivers despite mandates to purchase automobile insurance. One reason cited for the ineffectiveness of individual mandates is that they are not accompanied by premium subsidies for low-income drivers.

In the absence of effective individual mandates, markets for automobile insurance can suffer from the “free-rider” and adverse selection market failures. The presence of safety nets leads some people to “free-ride” by driving uninsured. Two factors make it more attractive to drive uninsured: first, low-income uninsured drivers have few resources against which to collect when they are at fault; and second, if the at-fault party is unable to pay for damages, the insurance of the damaged party often pays. These safety nets are analogous to health sector safety nets such as charity care and the Emergency Medical Treatment and Active Labor Act (EMTALA). Further, compared to people with low incomes, those with higher incomes have greater motivation to be insured because they have more wealth at risk before safety nets become available.

Smith and Wright (1992) found that the presence or absence of adverse selection was responsible for the large geographic variability in automobile insurance premiums. They found that the premium differences for comparable policies were too large to be explained by differences in driver risk alone. Rather, premium differences could be explained, in large part, by differences in the proportion of low-income uninsured drivers in different areas. Where there are large numbers of low-income uninsured or underinsured drivers, premiums are higher because damaged parties with insurance are more likely to be forced to collect from their own policies. Even if all drivers were of uniform risk, the presence of uninsured drivers would create a type of adverse selection by forcing up the expected costs and premiums of those with insurance. In turn, high premiums discourage some drivers from purchasing insurance, thereby exacerbating the problem of the uninsured. This negative cycle is an example of the adverse selection market failure, which can affect health insurance markets as well.

Individual Mandates for Health Insurance in Other Countries

Approaches to universal coverage fall into two broad categories: (a) single-payer systems; and (b) mandated coverage. Single-payer systems may involve public financing of health services, as in Canada, or public financing and delivery of health services, as in Great Britain. The issue of mandated purchase of health insurance is not relevant to single-payer systems since under such systems, universal coverage is provided by the government.

Nations that have instituted individual or employer mandates to purchase health insurance generally approach but do not achieve 100% universal coverage. Most Western European countries mandate that insurance be purchased through a system of “sickness funds.” Typically, employers and employees bear the costs of health insurance in agreed

proportions, and the government may subsidize the funds as well as regulate them. Governments usually contribute toward coverage of groups who are difficult to insure (Center for Health Policy Research, AMA, 1989). Ballard and Goddeeris (1998) note that mandated-type proposals having the goal of universal coverage must include some system of subsidies for the poor, regardless of whether the mandate is on the individual or the employer. Germany, France, and Japan are examples of countries that have achieved near-universal coverage through individually mandated insurance.

In Germany, health insurance is provided by non-profit, non-governmental "sickness funds" regulated by the government. Membership in a sickness fund is determined by occupation, employer or location. In general, Germans have no choice of fund and are required to purchase insurance from their assigned funds, although some occupation groups have choice between a regional fund and an occupational fund. Employers are required to contribute to premiums but there is little government subsidization of premiums. Government regulations require premiums to be community rated or on a sliding-scale basis. Only those above an income threshold are exempt from the mandate to join a fund; they are permitted but not required to purchase private insurance outside the fund system. Only about 100,000 people are uninsured in Germany (White, 1995). Although health insurance is not mandated in Switzerland, 96% of the population is insured through more than 500 sickness funds. The high rate of coverage is due largely to generous government subsidization of health insurance (AMA, 1984).

ADVANTAGES AND DISADVANTAGES OF AN INDIVIDUAL MANDATE

As previously noted, potential advantages of an individual mandate to purchase health insurance include: (a) universal coverage; (b) avoidance of the "free-rider" problem; and (c) avoidance of adverse selection. Some policy analysts believe that under a voluntary system, a significant number of people will not purchase coverage, particularly among those who are currently uninsured (e.g., those with low incomes, the young, and the healthy). They cite the erosion of coverage under the current, voluntary system as evidence that a mandatory approach is needed to guarantee health insurance coverage for all Americans, and to ensure that risk pools include low-risk individuals. According to this view, without either mandated coverage or a national health care system, there will be too many uninsured "free riders" whose care will ultimately be paid for by the rest of society through higher taxes and higher premium prices. Proponents of an individual mandate are skeptical that a voluntary system based on tax incentives will be able to expand coverage appreciably, especially if implemented in a budget-neutral manner. Further, an individual mandate coupled with tax subsidies for the poor would require less tax revenue than a single-payor system, thereby reducing the disincentives to work that go along with taxation.

Despite these potential advantages, there are serious philosophical and logistical drawbacks to imposing an individual mandate to purchase health insurance. Philosophically, an individual mandate can be viewed as coercive, particularly in the context of tax credit proposals to increase individual choice. An individual mandate could also permit the government to renege on its commitment to support health insurance through tax credits and other subsidies.

Further, a variety of logistical challenges would seriously limit the effectiveness of an individual mandate, as is the case with automobile insurance. Considerable resources which could be used to provide additional tax credits, health care or other goods and services would need to be devoted to identifying the uninsured, and then somehow compelling them to purchase health insurance. This would be especially problematic for certain sectors of the population, such as those with low incomes and seasonal laborers. Because of these philosophical and practical problems, an individual mandate would probably be politically unpalatable and could jeopardize the political viability of a tax credit proposal.

Perhaps the strongest argument against an individual mandate is that it might not be necessary to achieve a reasonable level of health insurance coverage. Income-related, refundable tax credits will give low-income individuals unprecedented market power, and the market will respond by providing more insurance products to fill their needs. Thus, tax-based incentives to purchase insurance, coupled with a greater tax credit to the low-income to assist them in obtaining health insurance could lead to virtual universal coverage. Tolerating the relatively small number of people choosing to forgo insurance under such a voluntary system is preferable to resorting to a compulsory approach.

ALTERNATIVES TO AN INDIVIDUAL MANDATE

In addition to an individual mandate, there are a variety of other policy options that can be used to expand health insurance coverage. One can think of policies to promote coverage as lying on a continuum between purely voluntary policies at one end and purely compulsory policies at the other, with mandated coverage lying at the compulsory end. Within this framework, policies to expand insurance coverage have various degrees of volunteerism or compulsion. Policies can be used alone or in combination with other policies. It should be noted that no approach, even a compulsory one, will achieve 100% universal coverage.

A variety of tax-based incentives can be used to encourage the purchase of health insurance. One tax-based approach would make the tax credit contingent on the purchase of health insurance, so that if insurance is not purchased, the credit is not provided. Although this would have no effect on persons who prefer to go uninsured, it would encourage the majority of the population who recognize the value of health insurance to obtain coverage in order to qualify for the tax credit. Tax credits could be structured so that the size of the credit is large enough at each income level to induce virtually everyone to voluntarily purchase health insurance. Should this approach prove too costly to finance, other incentives or other policies could be instituted along with the tax credits in order to encourage the purchase of health insurance. CMS Report 4 (A-00), which is before the House of Delegates at this meeting, recommends the adoption of a number of principles for structuring a health insurance tax credit.

It is possible to have a penalty without having a mandate. Under this approach, individuals who do not obtain coverage would be assessed a tax penalty. Tax penalties could be a flat amount or they could increase with income. This tax-based approach is more compulsory than positive tax incentives to purchase insurance described above but less compulsory than an outright mandate. Tax credits coupled with tax penalties could constitute a powerful "carrot and stick" approach to inducing the purchase of health insurance.

Individuals who do not choose to purchase health insurance on their own could be enrolled in "fall-back" plans or randomly assigned plans not of their choosing. Enrollment could occur automatically or only at such time as an uninsured person seeks (uncompensated) health care. Although automatic enrollment is compulsory, it *per se* is not punitive.

Financing coverage for the otherwise uninsured could be linked to revenue generated by unclaimed tax credits and/or tax penalties. Several proposals suggest that tax credits not used by the uninsured be channeled to state and local governments to finance safety net care for the indigent (Goodman, 1999 and Etheredge, 1999). Revenues from unclaimed tax credits could be used to fund a "fall-back" insurance plan, high-risk pools, Medicaid expansions or the direct provision of care. Similarly, tax penalties could be equal to the premium of some minimal insurance, with the penalty funds used to enroll such individuals in the fall-back plan. Designing the fall-back plan to be less desirable than privately purchased insurance would encourage the voluntary purchase of insurance.

Etheredge (1999) proposes that under a tax credit system, employers continue to facilitate the purchase of insurance. Regardless of whether insurance is purchased through the employer or elsewhere, there would be workplace sign-up and automatic payroll deduction for employees' premium payments. Employers would submit withheld premium payments to the plan chosen by the employee. If the employee did not specify a health plan, enrollment and premium payments would go to a plan assigned by the government. In order for employees to decline health insurance altogether, they would have to sign a statement explaining the tax credits and the benefits of basic health insurance. This approach would make the purchase of health insurance convenient and would reduce administrative costs. In the Medicare program, such automatic enrollment and deductions from Social Security checks have produced over 95% sign-up rates.

Another strategy for expanding health insurance coverage would be to impose a mandate only on individuals above a certain income level. Although this approach has the desirable goals of forcing those who can afford to purchase health insurance to do so without placing an undue financial burden on the poor, it would pose political and administrative difficulties similar to a general individual mandate. Further, people with large enough incomes to "go

bare" or self-insure do not pose a "free-rider" problem.

HEALTH CARE SAFETY NET

The health care safety net recommended in Resolution 105 (I-99) has similarities to the existing Medicaid program and CHIP. Under both programs, the federal government provides grants to the states and the District of Columbia, as well as US territories to provide health care to the poor. Within federal guidelines, states are given broad authority in designing their individual programs in terms of eligibility and covered services. The amount of federal funding received by states for their Medicaid programs is inversely related to a given state's per capita income, with the richest states receiving a federal contribution of 50% of their total Medicaid expenditures, and the poorest receiving 73%. CHIP provides states even greater flexibility in program design and enhanced funding relative to Medicaid, so that federal match funding for CHIP ranges from 65% to 85% for the poorest states.

All states, the District of Columbia, and the U.S. territories have CHIP plans that provide coverage to children in families with incomes too high to be eligible for Medicaid and too low to afford private insurance. States may receive CHIP funds by expanding their existing Medicaid programs to children living in families with higher levels of income than allowed under Medicaid. Other states may establish entirely separate programs, which allows them to provide less comprehensive benefits and to require cost-sharing on the part of beneficiaries. Still other states may establish programs that combine elements of Medicaid expansion and stand-alone program techniques. For example, a state could expand Medicaid for children up to a higher percentage of the federal poverty level than offered under Medicaid alone, as well as enroll children at even higher levels of poverty, such as 250% of the federal poverty level, in another stand-alone program.

Labeling a state's plan as an expansion, separate program or combination approach can be difficult because of the wide variation in plan structures. For example, some states with stand-alone plans offer the same benefits as Medicaid, making them look like expansions. In addition, some states with expansion programs may impose cost sharing for enrollees covered with CHIP funding because their existing Medicaid programs operate under a special waiver that allows them to do so. Therefore, there is some discrepancy in the relative number of each type of plan, but in general state CHIP programs are distributed into 21 Medicaid expansions, 16 separate programs, and 13 combination programs. The District of Columbia and the U.S. territories all have plans designed as Medicaid expansions. The preponderance of Medicaid expansions can be largely attributed to the fact that states had a limited amount of time to design their programs and expansion of an existing program presented the fewest administrative complexities. Over time, it is expected that more states will develop stand-alone or combination programs to maximize their impact in providing coverage to more children, while providing them greater budgetary control relative to Medicaid expansions.

Whereas AMA policy supports that tax credits be available to everyone, and there are existing safety net programs, the Council believes that the creation of a new safety net program for the poor is unwarranted. However, the Council does believe additional policy is needed to assure that those without means to purchase coverage receive their tax credit in advance of year's end. The AMA proposal to expand health insurance coverage, as articulated in Policy H-165.920, could be administered as a voucher system that provides recipients with a choice of health insurance. Vouchers can take many forms, and all essentially allow some level of recipient choice through government funding of specific goods and services, rather than unrestricted direct cash assistance. A popular form of government assistance, vouchers are currently used to provide a variety of services, including food and nutrition through food stamps, child care via the Child Care and Development Block Grant program, housing through Section 8 rental certificates, and education through the Pell Grant program for higher education and through several state demonstration projects for primary and secondary private education.

The issuance of tax credits as supported in Policy H-160.920[12] would most efficiently go directly to entitled individuals at the end of a given year for which such credits applied. A voucher mechanism to distribute tax credits for the purchase of health insurance would enable individuals with low incomes to secure coverage despite their lack of sufficient funds to purchase insurance without the immediate assistance of the tax credit due to them. The structure of such a voucher mechanism should be allowed sufficient flexibility to accommodate political and financing

considerations. In general, however, welfare agencies and/or other entities should be authorized to verify income eligibility for such vouchers, and either the same or different appropriate agencies could issue vouchers for the amount of tax credit due the individual. Depending on the level of public commitment to expanding health insurance coverage and the budget environment in any given year, it should not be necessary for entities to wait until year's end to receive the credit due the individuals to whom they issue vouchers.

Accordingly, the Council believes AMA policy on individually owned insurance should be augmented by supporting the creation of a mechanism or mechanisms whereby tax credits could be made available as advanced payments through organizations such as local welfare agencies and/or other appropriate entities, which could verify income status and issue vouchers immediately for the amount of credit due individuals. The entities could then receive the tax credit due the individuals to whom they provided vouchers. Such mechanisms for assuring that tax credits are a feasible option for those with low incomes is necessary to ensure that individually owned insurance is viable for everyone.

DISCUSSION

The Council continues to believe that an individual mandate has serious drawbacks that can be avoided by using tax-based incentives and other policies to promote health insurance coverage. Besides lacking political viability, an individual mandate is undesirable because it would permit the government to renege on its commitment to subsidize health insurance, and would entail an unreasonable administrative burden to enforce. Rather, with appropriately structured tax credits, virtually all individuals will face powerful incentives to obtain and maintain coverage. Income-related, refundable tax credits will give low income individuals unprecedented market power, and the market will respond by providing more insurance products to fill their needs.

Regarding the safety net modification recommended in Resolution 105 (I-99), the Council notes that the AMA proposal would apply to individuals who are uninsured, but who would purchase coverage if they received tax credits for doing so and had affordable options, as well as those who currently have employer-sponsored benefits. Although there may be some indigent individuals who may not purchase coverage, public safety net programs exist for the poor, and AMA policy favors expanding eligibility for these programs in the absence of private sector reform. In addition to the existing safety net programs for the low income, EMTALA assures that acute emergency conditions will be treated regardless of ability to pay. Assuming the continuation of public sector programs such as Medicaid and CHIP, and the continuation of efforts to expand eligibility and enrollment in these programs, supporting the establishment of an additional and separate safety net for an unknown population of individuals who do not receive the tax credit would seem a premature commitment of public funds. The Council does believe, however, that there is a need for additional policy to assure that low income individuals are able to access the tax credits in advance of year's end so that they are able to purchase coverage.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 105 (I-99), and that the remainder of the report be filed:

1. That the AMA amend Policy H-165.920 by addition of the following principle:

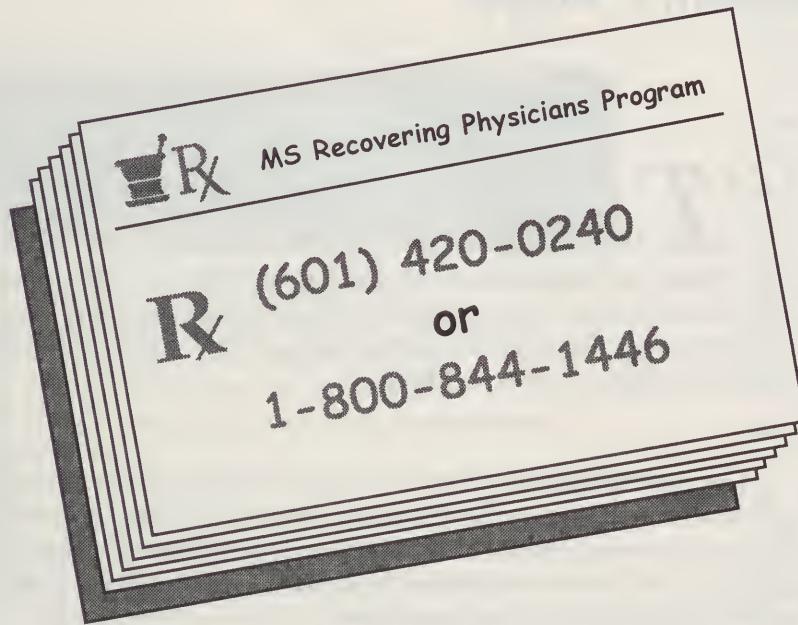
The AMA supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage.

2. That it is the policy of the AMA that organizations such as local welfare agencies and/or other appropriate entities be authorized to verify income status and issue vouchers immediately for the amount of tax credits due individuals; thus advancing funds to purchase the coverage for low-income persons who could not afford the monthly out-of-pocket premium costs.

References for this report are available from the AMA Division of Health Care Financing Policy. Reprinted with permission, American Medical Association House of Delegates Reports and Resolutions, Council on Medical Service Report #5 and # 6 of A-2000.

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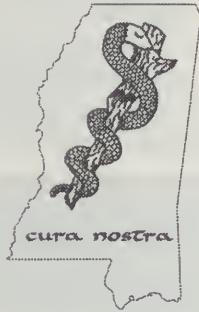
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Politics

**Candace E. Keller, M.D., M.P.H.
The President's Page**

“The credit belongs to the man who is actually in the arena, who strives valiantly; who knows the great enthusiasms, and great devotions, and spends himself in a worthy ... cause, who at the best, knows the triumph of high achievement; and who, at the worst, if he fails, at least fails while daring greatly, so that his place shall never be with those cold and timid souls ... who know neither victory nor defeat.”

—Theodore Roosevelt

I am confident that most, if not all, of us in the medical community would prefer to devote our time and energy to the practice of medicine rather than to the arena of politics. My friends and colleagues, in today's world, our involvement in both state and national politics is no longer an option; it is an absolute necessity! With this President's Page, I call to your attention two opportunities requiring action on your part.

First, Mississippi's upcoming state Supreme Court elections are crucial and will determine whether our highest court will be composed of judges friendly to plaintiff lawyers or by judges who are fair and objective.

Opponents to tort reform are mobilizing their forces. Over the last few years, a group known as the Institute for Consumers and the Environment Political Action Committee, or ICE PAC, has emerged as a major campaign contributor. ICE PAC appears to further the political interests of its primary funders - plaintiff lawyers. In 1999, ICE PAC spent just under \$372,000 on political candidates. Documents in the Secretary of State's office show that in 1999 alone, attorney Richard "Dickie" Scruggs — the brother-in-law of Senator Trent Lott and recipient of more than \$1 billion in legal fees from the state's tobacco litigation — donated \$80,000 to ICE PAC.

Ladies and gentlemen of MSMA and MSMA Alliance, if you have not joined the Mississippi Medical Political Action Committee (MMPAC), please do so immediately! For more information, contact our MSMA Department of Governmental Affairs at 601-853-6733.

Secondly, as you are well aware, on the federal front, we have supported bills to obtain antitrust reform and to ensure patients' rights to quality medical care. In the wee hours of June 30, 2000, the U.S. House of Representatives passed H.R.1304, the Campbell antitrust bill, officially named the Quality Healthcare Coalition Act. The final vote was 276 - 136 with all five Mississippi Congressmen voting YES for final passage.

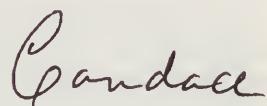
Likewise, in the late night hours of June 29, 2000, Senator Don Nickles (R-OK) offered a sham Patients' Bill of Rights amendment, which falls short of ensuring meaningful patient protections, to an appropriations bill in the Senate that passed by a vote of 51 - 47. All Republican senators with the exception of Senators McCain (AZ), Fitzgerald (IL), Specter (PA), and Chafee (RI) supported the Nickles' poison amendment. It remains uncertain whether the House - Senate conference committee will resume its efforts to craft a bicameral, bipartisan bill.

Our esteemed Senate Majority Leader Trent Lott appears to be more attuned to the voices of the insurance and managed care industries, than the voices of the people

and patients! In a July 1, 2000, New York Times article, following passage of the Campbell bill, Mr. Lott expressed his opposition to the bill and was quoted as saying, "I don't think we need more lawsuits in America. And I don't think we need more, you know, labor unions in America. And that's basically what they're trying to do. So I certainly don't look on it favorably and I won't be trying to find a way to pass it, I'll tell you that."

With all due respect, our Senator seems to be confused. Ensuring quality medical care for all patients, ensuring a level playing field for all physicians WITHOUT the necessity of labor unions, and decreasing the number of medicolegal lawsuits is precisely what the

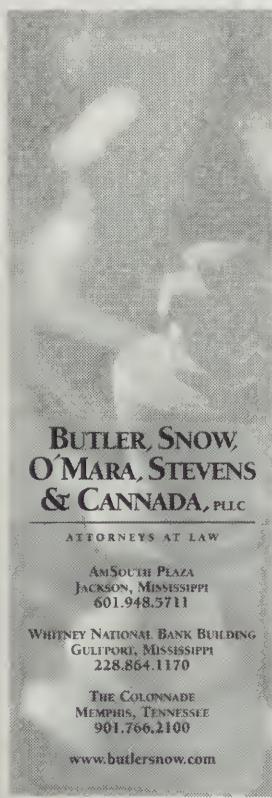
Norwood-Dingel Patients' Bill of Rights, what the Campbell antitrust bill, and eventually what meaningful tort reform are all about! I urge every Mississippi physician, spouse, and patient, just as we are experiencing the natural heat of summer, to keep up the political heat by personally calling, writing or emailing Mr. Lott. Urge him to do what's right for patients in Mississippi and America by supporting real antitrust reform and patients' rights to quality medical care.



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PATIENT PROTECTIONS

The competing patient protection bills are argued furiously in Congress and in the presidential campaign. One version, the Democratic, provides real patient and doctor protections; the other, the Republican, while labeled a patient protection act, instead protects the insurance industry by insulating them from lawsuits. Will either one change the dismal situation patients and doctors find themselves in? I am beginning to doubt it. Yes, I do what I can—phone calls, e-mails, etc.—to support the Democratic bill. But I am increasingly disturbed by the thought that, to the extent a passed bill has any teeth, the costs for the insurance companies and, therefore, premiums paid by employers, will increase. Increased costs collide directly with the fatal flaw in our system—health care insurance provided by employers is voluntary. Insurance can be and is dropped at whim. Few people can afford the premiums on their own.

Even in our booming economy, the number of insured people in the U.S. rises every year. Imagine what will happen in a down turn. How long can this go on?

Reform of the managed care industry is desperately needed. People are fed up with an industry siphoning off 25% of premiums toward corporate profits. They are fed up with an industry seeking to insure only those healthy people who do not need insurance. And they are fed up with arbitrary withholding of care to those unlucky enough to need it.

Every incentive of the system leads to these results, and it is difficult to see how a patient protection bill will alter this situation without increasing costs. It is also difficult to see how managed care should not be regarded as one of the colossal failures in our experience.

I do not know how this situation will end, but I do know this—every day the problem worsens and the pressures build. Insurance companies are approving payment for far fewer days than doctors think are needed. Uninsured patients arrive at the emergency room in increasing numbers, sicker than if they had insurance and felt they could have come earlier. Emergency room call for the medical staff is much more difficult than ten years ago. Hospitals put increasing pressure on doctors to reduce Medicare patients' lengths of stay to maintain financial viability amidst the sea of uninsured.

It is rationing, pure and simple, but a wild, aimless form of rationing without public discourse on priorities. Who, after all, really knows why he has been turned out of the hospital—or not allowed in? The answer is in the wind, somewhere, out there, and sooner or later citizens will get frustrated and mad enough to demand mandatory insurance. Americans, after all, have never been much for selling seats in a lifeboat.

—Leslie E. England, M.D.
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal.



Looking Back: Report of a Case

Selected and edited by Lucius Lampton, MD, Associate Editor

[Since Hippocrates, physicians have exchanged anecdotal cures of what worked in a strange situation. Before the era of huge clinical trials, the following report provides such a perspective. It was written by Greenwood physician D. S. Humphreys, M. D. and was presented at the Thirty-eighth Annual Session, held at Jackson on April 19-21, 1905.

"Looking Back" will be a monthly feature of the Journal. This editor will select interesting articles published in past issues of the Journal of the Mississippi State Medical Association, the Mississippi Doctor, and the Transactions of the Mississippi State Medical Association. Any doctors with old volumes of these publications are invited to submit articles from them for publication in "Looking Back."] — Ed.

On December 19th 1904, I was called to attend Mrs. T. in her first confinement. The lady was undersized and about eighteen years old. Head was presenting in the first position, cervix unyielding. The labour was tedious and the woman becoming tired out, it was thought best to apply forceps under chloroform. Dr. Brister delivered the child while I was administering the anesthetic. After the birth of the baby and the removal of the secundines, and whilst I had my hand on the uterus, there appeared a most terrific hemorrhage—such a prodigious flow of blood that I despaired of saving the woman's life. But holding on to the uterus with my left hand, I could plainly feel the pulsations of the abdominal aorta and the idea occurred to me of compressing it. I did this by firm pressure against the vertebral column, controlling the hemorrhage perfectly, and this pressure was maintained for twenty minutes with my left hand while kneading the flabby uterus with my right.

In an hour and a half there was another terrific hemorrhage, when the same treatment was applied with similar satisfactory results. After this, there was no more trouble.

Hypodermics of strychnia and ergot were administered. There were all the evidences of impending death in this case, pulse gone and woman gasping. No other method could have been prompt enough to have saved her. There was no time for the action of medicine, nor for the intra-uterine application of plugs, styptics or anything else.

In looking up the literature on the subject I find very little attention has been paid to it.

Much stress is laid upon tamponade, on gauze packing, hot water injections, applications of ice, vinegar and solution of perchloride of iron, the introduction of the hand, etc. None of these methods could have availed in the case cited because of the element of time; whilst getting ready to use any of these this woman would have surely died. Playfair, Harris, Sajous, Whitridge Williams of Johns Hopkins (1904) are all silent upon the subject, no mention whatever occurring of it in any of their published works. Hoyt, of New York, refers to it to condemn it as a doubtful theory. Grandin and Jarmin do not refer to it in their magnificent work at all. Delee recommends it as worthy of trial while preparing for introduction of gauze tampon. The subject is dismissed with a few lines by the American Text Book of Obstetrics with the statement that Rudiger of Tubingen first suggested it. Kaltenbach admits its usefulness, which he attributes to the stimulation of the uterine plexus by irritation, thus producing contraction of uterus, and not to the shutting off of the blood supply to the uterine vessels.

This silence, or very slight attention, of the standard authorities suggests the inutility of the measure and it is dangerous to predicate a practice on a single case, but I am persuaded that on this contingency hinged the life of this woman and I urge a trial of it in suitable cases, further expressing the hope that none of you will ever have occasion to need it.

—D. S. Humphreys, M.D., Greenwood
Transactions of the MSMA, 1905, pages 190-191

Let's "FACE" It!

How many times have our youth been offered a drink today? We're not talking soda or lemonade here. We're talking about an alcoholic drink—and why not? The messages are everywhere! Disc jockeys, television, store displays, community and sporting events and newspapers offer our youth a drink on a daily basis.

I really wasn't aware of how often these "signals" were put in front of our youth until I attended AMAA Confluence meeting in Chicago in October, 1999.

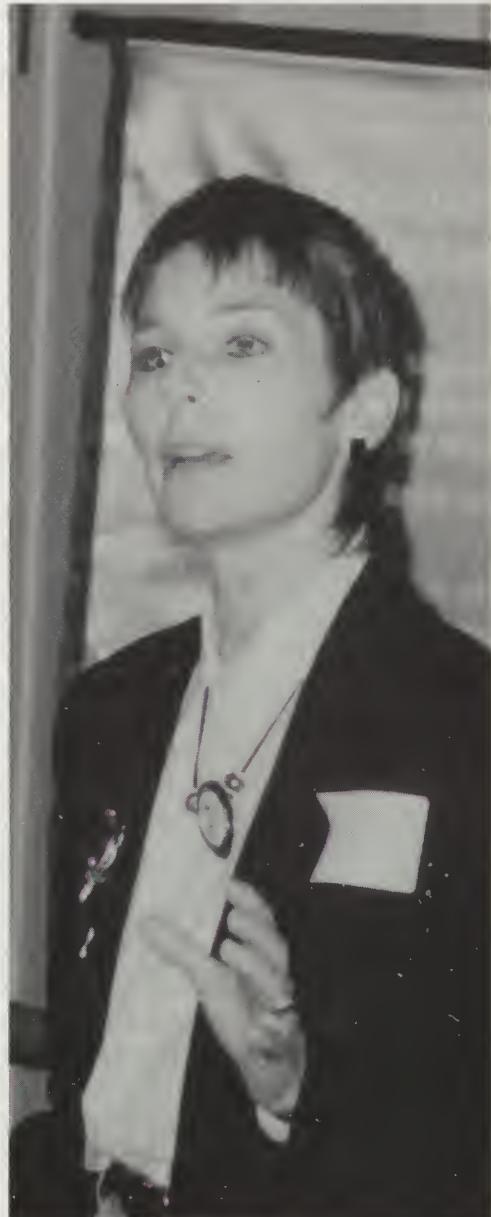
This is where I began my involvement with FACE. My roommate, who is also my Coast Alliance co-president, and I knew we had to bring this project back to the Coast communities. FACE (Facing Alcohol Concerns through Education) is a national non-profit organization that focuses specifically on alcohol issues.

I guess you could say that these issues became as clear as the nose on my FACE. We came home and immediately began planning our February meeting around introducing FACE to our Coast alliance members and local community leaders.

We invited Penny Norton, founder of the FACE program, to be our guest speaker. Along with a record number of alliance members, there were local school, political and law enforcement officials present. This encouraging turnout assured us that people were eager to listen and help with a very real and present problem on the Mississippi Gulf Coast—and in every community.

FACE works in three areas. First, media development on key alcohol issues designed to help people make connections between alcohol and critical public health concerns. Second, training on community organization for the reduction of alcohol-related problems among youth and adults. Third, national advocacy for policy change that reduces risk and liability related to alcohol sales and service, increases safety of the community and enhances the quality of life for individuals.

During the past year, FACE has traveled to 16 states and Puerto Rico conducting training for groups that are organizing to reduce alcohol problems within their communities. The Coast Medical Alliance has chosen to get involved with this effort in our community. We are presently working with community leaders on current policies and how they are enforced (or not enforced) in our schools and counties when underage youth are found with alcohol. We are also in the process of locating funds



Penny Norton, national director of FACE (Facing Alcohol Concerns through Education), a preventive alcohol program, spoke to Alliance members during their annual meeting.

for local people to be trained in the efforts of reducing alcohol access for our youth.

Youth access to alcohol, and the problems that accompany it, represent great issues that affect every community today. We in Mississippi are taking a step forward to establish a statewide effort in training groups that will work toward reducing some of these tragic problems related to alcohol abuse.

FACE is the means by which we hope to accomplish this goal. Since its inception ten years ago, FACE has never taken state, federal or beverage industry funding. As a result of this, they are free from censorship or influence. Its greatest strength lies in translating high quality messages into community action that reduces alcohol related problems. FACE serves as a voice for policy changes.

This is not an easy job and the stakes are very high. But the return is enormous. We feel that this is a project that will affect everyone at one time or another. We think it is worth all the time and effort that it will take to implement. The youth of Mississippi are our future. They are certainly worth it.

*—Patricia Benefield
Co-President, Coast Medical Alliance*

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BELLAN, JOHN ALEXANDER, Jackson, Born Jackson, MS, February 27, 1960; MD Tulane University School of Medicine, New Orleans, LA; internal medicine residency, John Hopkins Hospital Baltimore, MD, 1993-95; cardiology fellowship, John Hopkins Hospital, 1995-99; elected by Central Medical Society.

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Memphis, TN; otolaryngology residency, Denver, Co., 1992-96; elected by Delta Medical Society.

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State University School of Medicine, New Orleans, LA, 1996; family medicine residency, University Medical Center, Jackson, MS, 1996-99; elected by South MS Medica Society.

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MCGRAW, DONALD V., Vicksburg, Born Houston, TX, July 31, 1947; DO Fort Worth, TX 1996; family practice residency, University of Alabama, 1996-99; elected by West Medical Society.

MOSES, DONALD G., Vicksburg, Born California, March 31, 1960; MD Louisiana State University School of Medicine, Shreveport, LA, 1987; pathology residency, Baylor University Medical Center, Dallas, TX, 1987-92; cytopathology fellowship, National Cancer Institute, Bethesda, MD, 1998-99; elected by West Medical Society.

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ROSA, LOUIS, Tupelo, Born New York, August 31, 1952; MD Georgetown University College of Medicine, Washington, DC, 1978; neurosurgery residency, Georgetown University Medical Center, AUGUST 2000

Washington, DC, 1979-84; elected by Northeast Medical Society.

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SUTTLE, SAMUEL KEITH, Louisville, Born Louisville, MS, July 11, 1952; MD University of Mississippi School of Medicine, 1973; family practice residency, Jackson Hospital & Clinic, Montgomery, AL, and University of Alabama, Birmingham, AL; 1979-81; elected by Central Medical Society.

TABORA, CAMILO B., Laurel, Born December 4, 1966; MD Faculty of Medicine and Surgery University of Santo Tomas, Manila, Philippines, 1991; internal medicine residency, Cabrini Medica Center, NY, 1994-96; elected by South MS Medical Society.

TAN, JEAN LIM, Laurel, Born Manila Philippines, September 30, 1966; MD College of Medicine University of the East, Quezon City, Philippines, 1991; internal medicine residency, Metropolitan Hospital, New York, 1994-96; elected by South MS Medical Society.

WAGLE, SAMEER, Laurel, Born Mumbai, India, August 8, 1963; MBBS Seth G.S. Medical College, Mumbai, India, 1984; pediatric residency, Children's Hospital of Philadelphia, 1996-97, neonatology fellowship, Children's Hospital of Philadelphia, 1993-96; elected by South MS Medical Society.

WEINER, ROGER D., Clarksdale, Born Brooklyn, New York, April 27, 1947; MD Hahnemann University School of Medicine, Philadelphia, PA, 1973; internal medicine residency, Hahnemann University, Philadelphia, PA, 1973-76; cardiology fellowship, Hahnemann University, Philadelphia, PA, 1979-81; elected by Clarksdale Medical Society.

YOUNIS, RAMZI TAMER, Jackson, Born Zoumieh, Lebanon, January 3, 1960; MD Medical School, American University of Beirut, Beirut, Lebanon, 1995; general surgery internship, American University of Beirut, Lebanon, 1984-85; general surgery residency, American University of Beirut, 1985-86; otolaryngology residency, American University of Beirut, 1986-89; pediatric otolaryngology fellowship, LeBonheur Children's Medical Center, Memphis, TN, 1989-92; elected by Central Medical Society.

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Jeanette Zurawski, M.D. has recently completed a three hundred hour course on Medical Acupuncture sponsored by UCLA (University of California at Los Angeles) and under the direction of Dr. Joseph Helms. This exceeds the requirements of most states in the United States for a physician to perform Medical Acupuncture. When a Board of Acupuncture is formed in the next one to two years, she will be eligible to become Board Certified, in Medical Acupuncture. She is Board Certified in Physical Medicine & Rehabilitation, and has practiced in the Tupelo area since 1989. She is a member of the American Academy of Medical Acupuncture. Auricular (ear) Acupuncture is a special interest. She has thus far successfully treated multiple pain issues, including TMJ (temporomandibular joint) pain, joint pain, spine pain, headache, and migraine headache. Other conditions successfully treated include sinusitis, bronchitis, weight problems, smoking, depression, anxiety, ADD (attention deficit disorder) emphysema, cough, asthma, constipation, and diarrhea.

Jesse H. Ezzell, Jr., M.D. has joined Dr. Stephen Johnson and Dr. Carolyn Cegielski of Jefferson Medical Associates in the practice of gastroenterology.

Charles A. Hollingshead, M.D. has recently received notification from the American Board of Family Practice (BFP), the certifying body for the specialty of family practice, that he has been recertified as a diplomate of the board. Dr. Hollingshead has been a board diplomate since 1972. He practices at East River Medical Clinic in Flowood, Miss., which is affiliated with the Preferred Medical Network. In addition to his practice, Dr. Hollingshead serves as the Medical Director of Preferred Medical Network. Family physicians earn diplomate status by passing the ABFP's certification examination, an intensive written test of a physician's knowledge in pediatrics, internal medicine, surgery, obstetrics, gynecology, psychiatry, prevention, and other aspects of family practice. Dr. Hollingshead has acquired 33 years of experience as a family practitioner, serving as a senior partner of a family practice clinic in Laurel for 20 years as well as a partner and staff physician with MEA Medical Clinic for several years. He served as assistant professor in the department of family medicine at the University of Missis-

sippi Medical Center and as the medical director for the West Jackson Family Medical Center of UMC prior to joining the East River Clinic in early 1999.

Walter C. Gough, M.D. of Mound Bayou was recently reelected president of the Mississippi Chapter of the American College of Emergency Physicians. The election was held at the Mississippi State Medical Association convention in Biloxi where Gough was a voting delegate for the Delta Medical Society. Dr. Gough has a medical practice in Ruleville where he serves the community. He has been a long-time member of both associations and has served the membership in various capacities.

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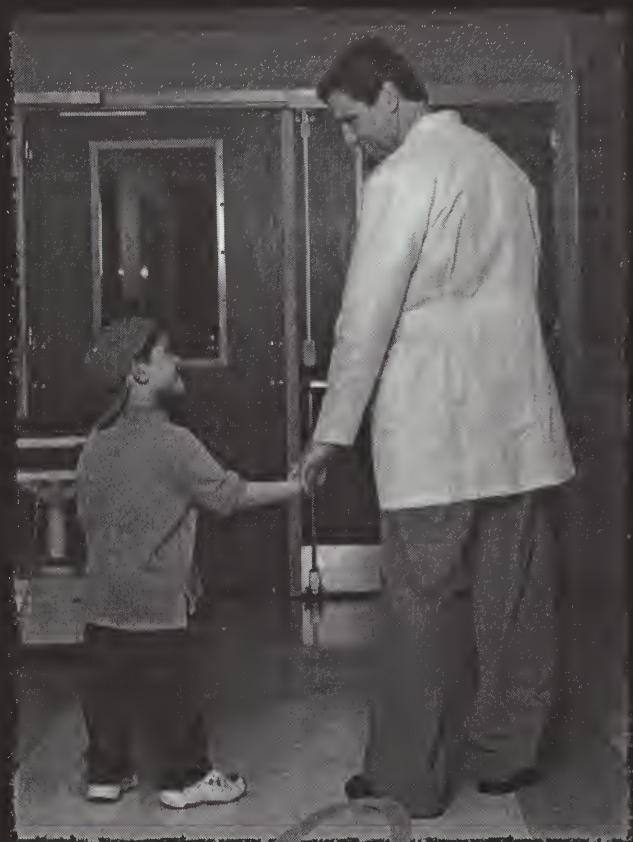
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What's New in the Treatment of Cerebrovascular Disease?: An Endovascular Perspective

Ian B. Ross, MD
Gurmeet S. Dhillon, MD

A BSTRACT

Surgical therapy currently allows for the correction of many pathologic conditions affecting the vasculature of the central nervous system. Recent advances in technology have given the cerebrovascular specialist further options in the minimally invasive sphere. Endovascular techniques, complimentary to surgery in some conditions, are poised to replace conventional open surgery in others. A review of current interventional radiological procedures for the treatment and prevention of ischemic and hemorrhagic stroke are herewith presented.

INTRODUCTION

In recent years, technological advances have allowed for the development of minimally invasive treatments for a myriad of diseases. Deformed and stenosed ducts and vessels in many organ systems can now be dilated, stented or reconstructed without surgically exposing the structure. Pharmacotherapy can be delivered directly, intrarterially, to most systems; and many vascular malformations and tumors can be embolized.

While this technology has touched all areas of surgery and medicine, its impact on the treatment of cerebrovascular disease may be the most profound. The majority of structural lesions that lead to the development of ischemic and hemorrhagic stroke have the potential to be treated endovascularly, accessed through a simple femoral arterial or venous puncture in the groin. Surgery may still be considered the gold standard for the treatment of many of these lesions, but rapid improvements in technology and technique are portending an overall switch to endovascular therapy as the primary

treatment. Presented here is a review of a current state of the art of this evolving field.

ISCHEMIC STROKE

Clot Lysis

Following the lead of the cardiologists in the treatment of acute myocardial infarction, stroke specialists have been able to demonstrate that early intravenous (IV) administration of thrombolytic agents in selected patients is of benefit after stroke. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study recently showed that if recombinant tissue plasminogen activator (rt-PA) is administered IV within 3 hours of the onset of stroke, provided that the CT scan shows no evidence of infarction or hemorrhage, patients have a net reduction of death and disability.¹ This reduction, however, is at the expense of an elevation in acute mortality and brain hemorrhage rates. Other trials have confirmed this experience and the current recommendation is that IV rt-PA may be justified in experienced centers in selected patients with stroke.²

The concept of intrarterial (IA) administration of such agents is attractive. Superior recanalization rates of cerebral blood vessels after acute stroke have been reported with IA administration of thrombolytics.³ Because of prohibitive costs, however, it is unlikely that a large, multi-centered, randomized, blinded study will be undertaken to determine if there is an advantage of IA thrombolysis over IV in the setting of stroke.

Technique:

The technique of IA thrombolysis is a relatively simple one. An arterial access sheath is usually inserted into a femoral artery and a diagnostic angiogram carried out to confirm the presence of clot. Then a 5 French or larger guiding catheter is introduced into the cerebral feeder leading to the obstructed artery. A smaller bore "microcatheter" can then be directed into the occluded arterial branch using fluoroscopic guidance, following which the thrombolytic agent is injected. (see Figure 1) Some operators try to manipulate the tip of the microcatheter into the clot for a more direct delivery. Technology is currently being developed to mechanically disrupt clots.

Balloon Angioplasty and Stenting

Carotid endarterectomy has become the accepted treatment for the prevention of stroke in patients harboring high-grade internal carotid artery stenosis in the neck.⁴ This procedure, given a low morbidity/mortality rate, has also been shown to be of benefit in patients with asymptomatic stenosis.⁵ The minimally invasive, endovascular technique of angioplasty and stenting is still considered to be experimental. Here the stenosis is not relieved by a physical removal of the atheroma; rather the plaque is crushed with a balloon after a stent has been deployed across the narrowed segment. This maneuver, which inevitably results in distal embolization of some plaque material and a "rough" endolumenal surface, is associated with a surprisingly low complication rate and has been gradually gaining acceptance.⁶ To improve safety, distal protection devices are being developed to minimize embolization of plaque material.⁷ Angioplasty and stenting is currently reserved for patients with carotid stenosis who are at high risk for surgery because of medical co-morbidity or who harbor anatomically difficult lesions such as recurrent or radiation induced stenoses or a very high bifurcation.

This technology has been demonstrated to be useful for the treatment of traumatic dissections and pseudo-aneurysms.^{8,9} Some intracranial stenotic lesions can also be treated with angioplasty and stenting¹⁰ and it is anticipated that these surgically difficult lesions will be routinely treated by an endovascular approach in the future.

Technique:

The technique of carotid angioplasty and stenting involves arterial access through a groin sheath and then, after completion of the diagnostic study, insertion

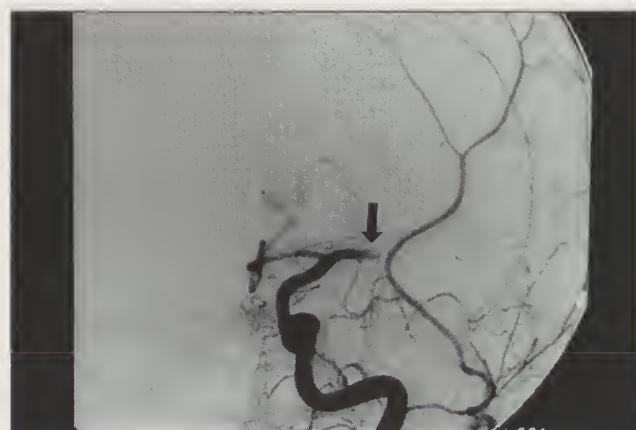


Fig 1.— A) left carotid arteriogram, demonstrating occluded left middle cerebral artery (MCA).



Fig 1.— B) left carotid arteriogram, same view, after intrarterial administration of thrombolytic—note recanalization of MCA.

of a large bore guiding catheter into the proximal part of the stenotic artery. A stent can then usually be gently pushed across the stenotic area and deployed. Finally, a balloon is used to crush the plaque and dilate the vessel, which is then held open by the mesh work of the stent. (See Figure 2).

HEMORRHAGIC STROKE

Brain Hemorrhage

The majority of hemorrhagic strokes seen in clinical practice are due to hypertension, often in combination with diabetes. The arterial rupture usually occurs in small vessels and, unfortunately, there is no endovascular treatment available. In certain instances, surgical evacuation of the clot can be of benefit to the patient. Hemorrhagic stroke is sometimes due to transformation of a non-hemorrhagic infarct into a hemorrhagic infarct. This transformation usually occurs some time after recanalization of the occluded vessel and reperfusion of the ischemic brain. This can be a complication of thrombolytic therapy for stroke. The presence of any he-

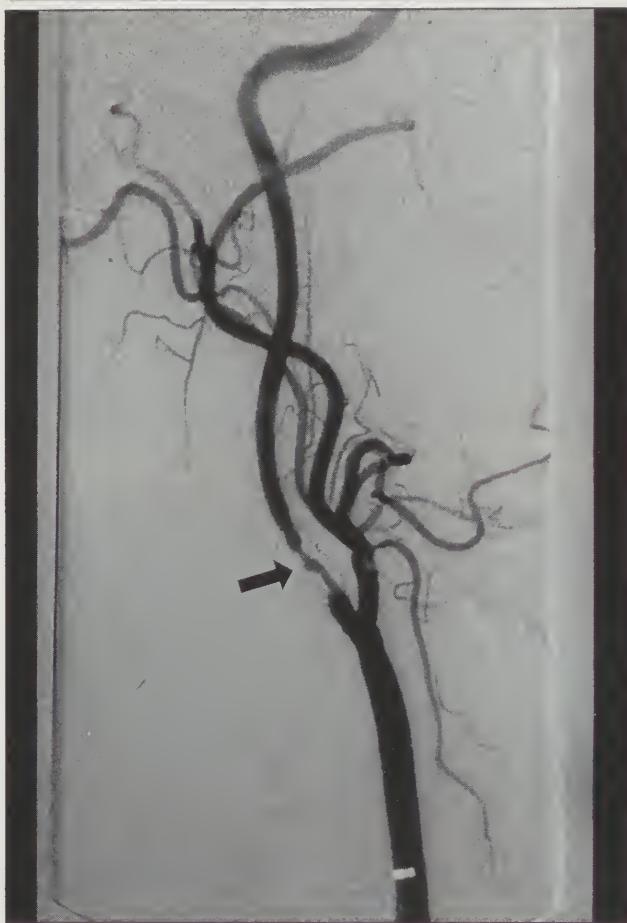


Fig 2.— A) right carotid arteriogram demonstrating stenosis of internal carotid artery (ICA) just distal to bifurcation of common carotid artery.



Fig 2.— B) right carotid arteriogram demonstrating improved patency of ICA after angioplasty and stenting.

matoma within the brain is a contraindication to thrombolytic therapy.

Aneurysmal Subarachnoid Hemorrhage

Aneurysmal subarachnoid hemorrhage, an important subset of hemorrhagic stroke, affects approximately 30,000 Americans every year.¹¹ Surgical clipping to prevent rebleeding in ruptured cerebral aneurysms, or first hemorrhage in unruptured ones, is still felt to represent the standard of care. As most aneurysms can now be tackled from an endovascular route, and experience has been growing, surgery is becoming a less popular option. Long-term results from the endosaccular embolization of cerebral aneurysms using Guglielmi Detachable Coils is not yet available. But studies of the short and intermediate-term results have demonstrated that these coils provide excellent protection from rebleeding after subarachnoid hemorrhage.¹² Large and giant cerebral aneurysms are less successfully treated because the coils that are used to pack the aneurysm will often compact or



Fig 3.— A) right carotid arteriogram demonstrating right ICA aneurysm that had caused recent subarachnoid hemorrhage.

migrate into thrombus in these lesions. Larger aneurysms can sometimes, however, be successfully treated endovascularly with parent vessel occlusion. To supplement distal blood flow, a distal arterial bypass will be needed at times with this procedure. While endovascular treatment of aneurysms that have bled does prevent

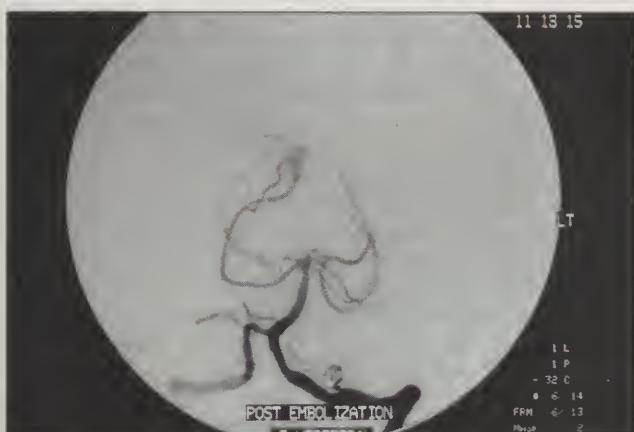


Fig 3.— B) right carotid arteriogram post-coiling demonstrating obliteration of lumen of aneurysm.

rebleeding, it does not reduce the incidence or severity of hydrocephalus or delayed ischemic deficits due to cerebral vasospasm. This last complication can, however, often be successfully treated with balloon angioplasty or the administration of calcium channel blockers.

Technique:

The technique of "coiling" of saccular cerebral aneurysms is as follows. Access is usually obtained through a femoral artery. After the diagnostic angiogram, a guiding catheter is directed into the appropriate cervical feeder. Following this, a microcatheter is directed using fluoroscopic guidance into the aneurysm. A series of small diameter soft platinum coils are then deployed into the aneurysm. These coils are gently threaded out the end of the microcatheter. They have varying helical diameters and lengths, are deployed sequentially, and only detached when an adequate and stable position of the coil has been confirmed. The goal is to fill as much of the aneurysmal sac as possible with coils. This prevents a filling of the aneurysm with blood and promotes thrombosis, with eventual healing. (See Figure 3).

Brain Arteriovenous Malformation

Brain arteriovenous malformations (AVMs) are responsible for a small subset of brain hemorrhage. They are also found in asymptomatic patients and sometimes present with seizures. Bleeding rates vary, but are lower in AVMs that have never bled. Lesions that have bled, and ones that are detected in younger patients, are often recommended for treatment.¹³ If the AVM is located in a relatively non-eloquent area of the brain and is small in size, surgical removal is generally prescribed. In other settings, however, an endovascular treatment

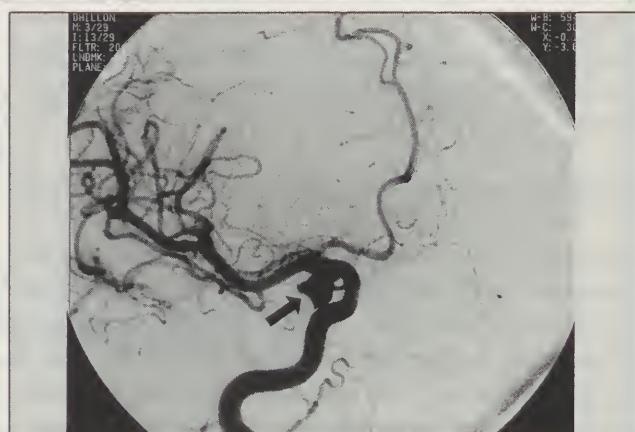


Fig 4.— A) left vertebral arteriogram demonstrating midline cerebellar arteriovenous malformation (AVM).

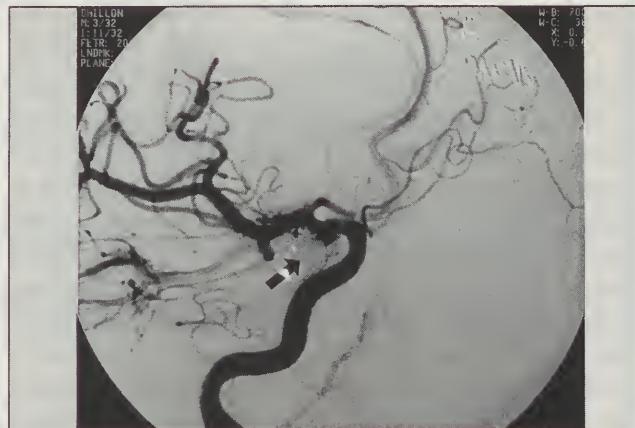


Fig 4.— B) left vertebral arteriogram, post-embolization, demonstrating near-total obliteration of AVM.

can be considered. A number of agents are currently used though none of these have been FDA approved. Small AVMs can sometimes be cured with embolization, but this modality is usually used as an adjunct to either surgery or radiotherapy. Larger AVMs, which are often not surgically treatable, are sometimes treated endovascularly.

In these cases the treatment is directed at the more dangerous architectural features of the AVM, including intranidal aneurysms and arteriovenous fistulae. When surgery and endovascular treatment is not an option, or when they are only partially successful at obliterating the AVM, stereotactic radiosurgery, which delivers a focal dose of radiation, is sometimes recommended.

Technique:

The technique of brain AVM embolization, again, requires arterial access through the groin and insertion of a guiding catheter into a major cerebral feeder using fluoroscopic guidance. A microcatheter is then directed into a feeding artery of the AVM. The embolization

material is injected if good flow control can be achieved in the feeding vessel, so that no embolization material backs up and occludes vessels supplying normal, adjacent brain. (See Figure 4)

Arteriovenous Fistulae

Arteriovenous fistulae, which are usually durally based, can cause symptomatology due to venous hypertension or brain hemorrhage. Some of these fistulae, bothersome because of associated cranial bruits, are treated even though they may not be causing neurologic deficit. While many are amenable to surgical treatment, most are currently best treated by the endovascular route, either venous or arterial.¹⁴

CONCLUSION

The greatest challenge, and indeed, the area of potential greatest gain, in the field of neurologic endovascular intervention is the timely treatment of thromboembolic stroke. Given the scattered and largely rural distribution of the population of Mississippi, it is unlikely that many patients, other than those located close to major medical centers, will be candidates for IA thrombolysis in the years to come. IV thrombolysis, which requires a CT scan of the brain to rule out hemorrhage before administration, may one day become a clinical reality in most community hospitals. Increased education of the population, with recognition of "brain attack" as being equivalent to a "heart attack", is essential. Thrombolytic treatment is useless unless it is started soon after the onset of stroke.

As regards the treatment of structural lesions, it is certain that technology and technique will improve and that less and less open surgery will be done for pathologically deformed blood vessels in the future.

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Ian B. Ross, M.D. is with the Department of Neurosurgery, University of Mississippi Medical Center, Jackson, Mississippi. He recently was visiting fellow in interventional neuroradiology at the Fondation Rothschild in Paris, France.

Gurmeet S. Dhillon, M.D., who works in the Department of Radiology at the University of Mississippi Medical Center, completed training in Neuroradiology at the University of Toronto and University of Pennsylvania.

Address for reprints requests and correspondence:

Ian B. Ross, MD
Department of Neurosurgery
University of Mississippi Medical Center
2500 North State Street
Jackson, MS 39216-4505
Phone: 601-984-5710
FAX: 601-984-5733
e-mail: iross@neurosurgery.umsmed.edu



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Physician-Based Tobacco Dependence Interventions: Review and Clinical Practice Recommendations

Patrick O. Smith, Ph.D.

Joe Griebler, M.A.

Thomas J. Payne, Ph.D.

Karen M. Crews, D.M.D.

Introduction

The use of tobacco products, a chronic condition requiring ongoing management, is the leading avoidable cause of illness, death, and health care expense in the United States.^{1,2} The tobacco-related mortality rate surpasses the annual death rate resulting from acquired immunodeficiency syndrome, suicide, homicide, traffic accidents, fire, alcoholism, cocaine, and heroin combined.³ Chronic tobacco use is associated with 80% of lung disease, increased risk of heart disease, stroke, peripheral vascular disease, and numerous forms of cancer.⁴ The annual costs of tobacco-related health problems and productivity losses are estimated to be \$50 and \$47 billion, respectively.^{5,6} Only 39% of managed care providers and 22 state Medicaid programs currently provide full or partial coverage for tobacco dependence treatment.^{7,8} This lack of treatment coverage is perplexing, from both clinical and economic perspectives. If 75% of the 50 million smokers were treated at an annual cost of \$6.3 billion creating 1.7 million quitters, the cost per quitter would be \$3,779.⁹ This makes tobacco treatment more cost-effective than treatment of hypertension, hyperlipidemia, and some preventive screenings (viz., blood pressure and mammography).¹⁰⁻¹³

Seventy percent of tobacco users have contact with their a physician each year¹⁴ and 70 percent of users wish to quit.⁹ Physicians are properly positioned to be front-line tobacco interventionists.¹⁵⁻¹⁷ To capitalize on this situation, the National Cancer Institute (NCI) funded five research trials to develop practical, physician-based tobacco interventions.¹⁸⁻²² These trials comprised the foundation for the scientifically based clinical practice

guideline developed by the Agency for Health Care Policy and Research (AHCPR) in 1996²³ AHCPR, now known as the Agency for Healthcare Research and Quality (AHRQ), collaborated with seven other federal agencies to update this guideline, "Treating Tobacco Use and Dependence", published in June 2000.

Essentially, tobacco users are in contact with physicians regularly, and physicians now have an empirically based guideline for managing this maladaptive behavior in a manner consistent with chronic disease. This article briefly summarizes the physician-based tobacco intervention literature, provides an overview of the updated tobacco intervention clinical practice guideline 9, and describes resources and assistance available through Mississippi's ACT Center - A Comprehensive Tobacco Program.

Physician-Based Tobacco Cessation

Research efforts designed to demonstrate the efficacy of physician-based tobacco cessation programs date from 1979.²⁴ The field grew rapidly such that by 1988, Kottke, Battista, DeFriese, and Brekke were able to conduct a meta-analysis of 39 controlled tobacco cessation trials.²⁵ Results demonstrated that brief (i.e., 3 minutes) face-to-face tobacco interventions provided across multiple sessions by multiple healthcare professionals led to increased patient quit rates at six months. The total number of months over which patient contact occurred that included a tobacco cessation component predicted 12-month abstinence. A subsequent review by Ockene and Zapka²⁶ con-

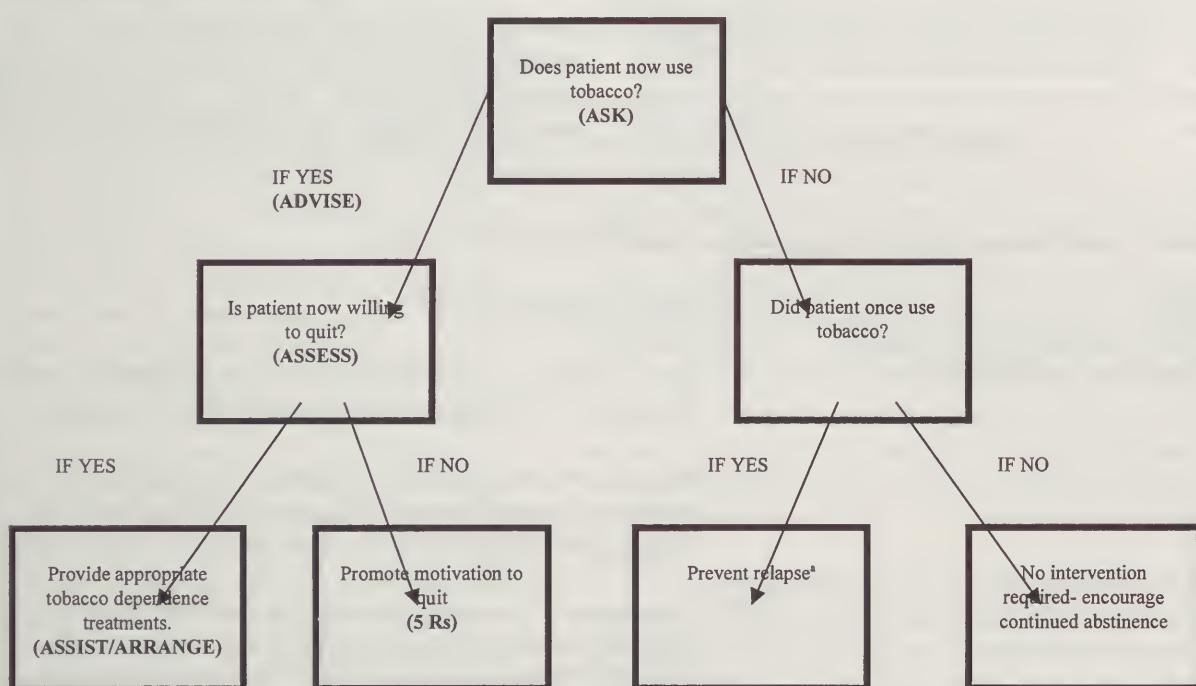
cluded: 1) physician-based interventions significantly reduce tobacco use; 2) there is a direct correlation between intervention time and patient quit rates; 3) the greater the number of modalities used (e.g., pharmacotherapy, various clinic staff), the greater the quit rates; 4) educating physicians on tobacco cessation methods leads to greater professional self-efficacy (i.e., confidence to apply the intervention); and 5) tobacco user health status influences physician behavior. However, for more than two decades, there has been consistent evidence that physicians fail to intervene with tobacco users.⁹ This is partially the result of an historical lack of institutional or organizational support for the individual clinician. More recently, there has been an emphasis in the current practice guideline on "coordinated care," wherein supportive system interventions are employed to assist the physician in delivering tobacco cessation services. System interventions include tobacco user identification, patient educational materials, clinician reminder systems, telephone counseling, use of non-physician interventionists, and identifying a tobacco treatment coordinator. When used in concert with physician-based treatments, system interventions substantially increase quit rates.²⁶ The clinical practice guideline, "Treating Tobacco Use and Dependence"⁹

attempts to "institutionalize the treatment of tobacco dependence" through coordinated interventions.

Clinical Practice Guideline Review

"Treating Tobacco Use and Dependence" emphasizes treating tobacco dependence as a chronic condition requiring ongoing assessment with brief, focused clinical intervention within a systems framework. Understanding tobacco dependence as a chronic condition with relapsing and recycling components is a critical perspective for successful physician intervention. Adherence to a chronic management model for treating tobacco dependence emphasizes the importance of physician counseling and advice, similar to that of diabetes, hyperlipidemia and hypertension. Every tobacco user must be identified, and their willingness to quit assessed. All tobacco users should be offered at least one of two treatments: 1) tobacco users *ready to quit* should be offered the "5 A's" clinical intervention, and 2) tobacco users *not ready to quit* should receive the "5 R's" treatment designed to increase quit motivation. Table 1 provides a tobacco treatment algorithm, including the appropriate points as to when the brief clinical interventions (5 A's: Ask, Advise, Assess, Assist and Arrange; 5 R's: Relevance, Risks, Rewards, Road-

Table 1: Algorithm for treating tobacco use.



*Relapse prevention interventions are not necessary in the case of the adult who has not used tobacco for many years.

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

Table 2: Brief Strategy A1. Ask – Systematically identify all tobacco users at every visit.

Action	Strategies for implementation
Implement an office-wide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is documented. ^a	<p>Expand the vital signs to include tobacco use, or use an alternative universal identification system.^b</p> <div style="border: 1px solid black; padding: 10px; margin-top: 10px;"> <p style="text-align: center;">VITAL SIGNS</p> <p style="text-align: center;">Blood Pressure: _____</p> <p style="text-align: center;">Pulse: _____ Weight: _____</p> <p style="text-align: center;">Temperature: _____</p> <p style="text-align: center;">Respiratory Rate: _____</p> <p style="text-align: center;">Tobacco Use: Current Former Never</p> </div>

^b Alternatives to expanding the vital signs are to place tobacco-use status stickers on all patient charts or to indicate tobacco use status using electronic medical records or computer reminder systems.

^a Repeated assessment is *not* necessary in the case of the adult who has never used tobacco or has not used tobacco for many years, and for whom this information is clearly documented in the medical record.

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

blocks, and Repetition) should be applied. In particular, the 5 A's can be implemented in as little as three minutes, however, there is a dose-response relationship between duration of physician-delivered counseling (i.e., min-

utes of contact) and effectiveness. The 5 A's are effective and each tobacco user willing to quit should be offered this treatment. Tables 2 - 6 detail the specific actions and strategies for implementing the 5 A's.

Table 3: Brief Strategy A2. Advise – strongly urge all tobacco users to quit.

Action	Strategies for implementation
In a <i>clear, strong, and personalized</i> manner, urge every tobacco user to quit.	<p>Advice should be:</p> <ul style="list-style-type: none"> ■ <i>Clear</i> – “I think it is important for you to quit smoking now and I can help you.” “Cutting down while you are ill is not enough.” ■ <i>Strong</i> – “As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you.” ■ <i>Personalized</i> – Tie tobacco use to current health/illness, and/or its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on children and others in the household.

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

Table 4: Brief Strategy A3. Assess – determine willingness to make a quit attempt.

Action	Strategies for implementation
Ask every tobacco user if he or she is willing to make a quit attempt at this time (e.g., within the next 30 days).	<p>Assess patient's willingness to quit:</p> <ul style="list-style-type: none">■ If the patient is willing to make a quit attempt at this time, provide assistance.■ If the patient will participate in an intensive treatment, deliver such a treatment or refer to an intensive intervention.■ If the patient clearly states he or she is unwilling to make a quit attempt at this time, provide a motivational intervention. <p>If the patient is a member of a special population (e.g., adolescent, pregnant smoker, racial/ethnic minority), consider providing additional information.</p>

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

Implementing the 5 A's treatment strategy, and thereby employing both behavioral strategies and pharmacotherapies, results in higher abstinence rates. Providing tobacco users with practical problem solving strategies, providing intra-treatment social support, and facilitating support in the patient's environment are effective behavioral strategies. Effective pharmacotherapies are recommended for all users attempting to quit unless there are circumstances prohibiting their use. Currently, five first-line FDA-approved medications exist for tobacco cessation: bupropion SR, nicotine polacrilex (gum), nicotine inhaler, nicotine nasal spray, and the nicotine patch. Specific medication decisions should be based on a variety of factors, including clinician familiarity with the medications, contraindications, patient preference, degree of nicotine dependence, prior patient experience with a specific pharmacotherapy and the adequacy of that trial, mood disorder and other psychiatric history, and concerns about or actual weight gain. Doses for nicotine replacement therapies should be adjusted when used with low-rate / low nicotine dependent tobacco users. Second-line pharmacotherapies are clonidine and nortriptyline.

For those patients unwilling to quit, the recommended course of action involves the implementation of the 5 R's. As described in Table 7, these are effective techniques to enhance motivation to quit.

Thus, implementations of the 5 A's and 5 R's by physicians and their staff are effective interventions for those both ready and not ready to quit tobacco, respectively. Additionally, those physicians who are supported through healthcare systems that institutionalize the tobacco intervention process achieve higher patient cessation rates.

The ACT Center - A Comprehensive Tobacco Program

The ACT Center, funded by a grant from the Partnership for a Healthy Mississippi to the University of Mississippi Medical Center (UMMC), is a recently established resource that was designed to develop and coordinate activities germane to understanding and managing tobacco use. Across its various domains of activity, the primary focus involves efforts within healthcare environments. The ACT Center's three core components of education / training, clinical services, and research can provide support to physicians and other healthcare providers statewide within the context of the implementation of the tobacco dependence treatment guideline.

The ACT Education and Training division provides educational experiences for healthcare providers, including physicians, utilizing an evidence-based curriculum entitled, "Taking ACTion for a Tobacco-Free Mississippi." This curriculum is based on the AHRQ guideline and the National Cancer Institute's "How to Help Your Patients Be Tobacco Free" program. Presently, the ACT Center is in the process of conducting 60 training sessions in Mississippi from July

Table 5: Brief Strategy A4. Assist – aid the patient in quitting.

Action	Strategies for implementation
Help the patient with a quit plan.	<p><i>A patient's preparations for quitting:</i></p> <ul style="list-style-type: none"> ■ <i>Set a quit date</i>-ideally, the quit date should be within 2 weeks. ■ <i>Tell</i> family, friends, and coworkers about quitting and request understanding and support. ■ <i>Anticipate</i> challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. ■ <i>Remove</i> tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, or car).
Provide practical counseling (problem solving/skills training).	<p><i>Abstinence</i> – Total abstinence is essential. “Not even a single puff after the quit date.”</p> <p><i>Past quit experience</i> – Identify what helped and what hurt in previous quit attempts.</p> <p><i>Anticipate triggers or challenges in upcoming attempt</i> – Discuss challenges / triggers, and how patient will successfully overcome them.</p> <p><i>Alcohol</i>-Since alcohol can cause relapse, the patient should consider limiting / abstaining from alcohol while quitting.</p> <p><i>Other smokers in the household</i> – Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or not smoke in their presence.</p>
Provide intratreatment social support.	Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. “My office staff and I are available to assist you.”
Help patient obtain extra-treatment social support.	Help patient develop social support for his or her quit attempt in his or her environment outside of treatment. “Ask your spouse/partner, friends, and coworkers to support you in your quit attempt.”
Recommend the use of approved pharmacotherapy, except in special circumstances.	Recommend the use of pharmacotherapies found to be effective in this guideline. Explain how these medications increase smoking cessation success and reduce withdrawal symptoms. The first-line pharmacotherapy medications include bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch.
Provide supplementary materials.	<p><i>Sources</i> – Federal agencies, nonprofit agencies, or local/state health departments.</p> <p><i>Type</i> – Culturally/racially/educationally/age-appropriate for the patient.</p> <p><i>Location</i>-Readily available at every clinician's workstation.</p>

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

Table 6: Brief Strategy A5. Arrange – schedule follow-up contact.

Action	Strategies for implementation
Schedule follow-up contact, either in person or via telephone.	<p><i>Timing</i> – Follow-up contact should occur soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated.</p> <p><i>Actions during follow-up contact</i> – Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience. Identify problems already encountered and anticipate challenges in the immediate future. Assess pharmacotherapy use and problems. Consider use or referral to more intensive treatment.</p>

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

2000 through June 2001. Physicians can receive training at various convenient locations throughout the state at no cost for training registration, materials, or continuing medical education credits. These trainings are open to all healthcare providers, and attendance by multiple staff within clinics is encouraged.

The Clinical Service division of the ACT Center provides interventions that are designed for nicotine-dependent tobacco users likely to benefit from treatment that is more intensive. This treatment option (which is provided at no cost) is currently available only at the ACT Center; plans are underway to extend the accessibility of this program. Physicians are encouraged to contact the ACT Center for consultative advice regarding difficult cases, or to refer patients. Plans for additional direct treatment activities include a limited school-based cessation program and a UMMC hospital-based consultation service, both scheduled for implementation in Winter 2000 to Spring 2001.

The Clinical Service and Education / Training divisions are integrated with the ACT Research division. Investigations span a broad agenda from basic science (MAO activity; viral presence in plaque; pulmonary function changes; airway inflammation), to applied clinical science (treatment of adolescent smokeless tobacco users / depressed adolescent smokers / diabetic smokers; relapse prevention with pregnant smokers), to public health initiatives (stepped care approach within primary care). Physicians interested in learning more about projects or in referring patients for enrollment in research protocols (many of which are treatment-focused) should contact the ACT Center.

Conclusions

Physicians comprise a well-positioned clinical profession for tobacco dependence intervention. The AHRQ clinical practice guideline, "Treating Tobacco Use and Dependence", provides physicians an effective treatment tool for reducing the most avoidable cause of health problems. The UMMC ACT Center provides physicians with continuing medical education, a clinical referral / consultation service, and research opportunities that support the institutionalization of tobacco intervention in Mississippi. The full text of the AHRQ guideline can be viewed at www.ahrq.gov. For more information about the ACT Center and its services, contact: (601)815-1180.

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Table 7: Enhancing motivation to quit tobacco – the “5 R’s.”

Relevance	Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient’s disease status, social/family situation health concerns, age, gender, and other important patient characteristics (e.g., prior quitting experience, personal barriers to cessation).
Risks	<p>Ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of the risks are:</p> <ul style="list-style-type: none"> ■ <i>Acute risks:</i> Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, increased serum carbon monoxide. ■ <i>Long-term risks:</i> Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (chronic bronchitis and emphysema), long-term disability and need for extended care. ■ <i>Environmental risks:</i> Increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.
Rewards	<p>The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:</p> <ul style="list-style-type: none"> ■ Improved health. ■ Food will taste better. ■ Improved sense of smell. ■ Save money. ■ Feel better about yourself. ■ Home, care, clothing, breath will smell better. ■ Can stop worrying about quitting. ■ Set a good example for children. ■ Have healthier babies and children. ■ Not worry about exposing others to smoke. ■ Feel better physically. ■ Perform better in physical activities. ■ Reduced wrinkling/aging of skin.
Roadblocks	<p>The clinician should ask the patient to identify barriers or impediments to quitting and note elements of treatment (problem solving, pharmacotherapy) that could address barriers. Typical barriers might include:</p> <ul style="list-style-type: none"> ■ Withdrawal symptoms. ■ Fear of failure. ■ Weight gain. ■ Lack of support. ■ Depression. ■ Enjoyment of tobacco.
Repetition	The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most

people make repeated quit attempts before they are successful.

Adapted from: Fiore MC, Bailey WC, Cohen SC, Dorfman SF, Goldstein MG, Gritz ER et al. Treating Tobacco Use and Dependence. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. 2000.

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Patrick O. Smith, Ph.D. is a clinical psychologist and Associate Professor of Family Medicine in the University of Mississippi School of Medicine.

Joe Griebler, M.A. is a psychology intern at Mississippi State Hospital.

Thomas J. Payne, Ph.D. is a clinical psychologist and Associate Professor of Medicine in the University of Mississippi School of Medicine. He is the Director of Research for the ACT Center - A Comprehensive Tobacco Program.

Karen M. Crews, D.M.D. is a dentist and Professor of Diagnostic Sciences in the University of Mississippi School of Dentistry. She is the Director of the ACT Center - A Comprehensive Tobacco Program.

Address for reprint requests and correspondence:

Patrick O. Smith, Ph.D.
Department of Family Medicine
University of Mississippi Medical Center
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Coding Concepts

Wanda L. Adams, CPC

Psychiatric coding provides a variety of challenges for today's coder since the insurance companies are now recognizing disciplines or providers other than physicians. Based on insurance companies' guidelines, you may be billing and receiving payment for the following providers of service:

- **Medical Doctors (M.D.)**
- **Doctors of Osteopathy (D.O.)**
- **Clinical Psychologists**
- **Clinical Social Worker (CSW)**
- **Clinical Nurse Specialists**
- **Pastoral Consultant**

For most insurance companies, psychiatric coverage is an "add on" benefit for the patient or a special contract agreement requiring additional coverage over and above the standard coverage typically provided by the patient's insurance contract. Additionally, payment for psychiatric coverage does not follow the same guidelines as those applied to medical or surgical services. For instance, many carriers will only pay a small portion of the service (e.g., \$25 a visit) or have a maximum dollar allowance for each calendar year (e.g., up to \$1,500).

Medicare Psychiatric Coverage Limits

Medicare has two payment formulas, Psychiatric coverage and regular coverage. Offices are more familiar with the regular formula that provides a Medicare payment of 80% of the allowed amount with patient having a 20% copayment. However, when the services are provided in relation to a psychiatric diagnosis, offices will find that payment is based on a psychiatric limit of coverage. The Medicare formula applies to psychotherapy codes and visits in the office setting. The

exception to the rule applies to consult codes which are paid according to standard reimbursement policies. Medicare's payment formula applies to any physician, regardless of specialty, who uses a psychiatric diagnosis as the reason for care.

Medicare's formula to reimburse outpatient psychiatric services is as follows:

Medicare payment: **Allowed amount x 62.5% payable at 80%**

Patient's copayment: **Allowed amount x 62.5% payable at 20%**

Additional Patient Responsibility: **Allowed amount x 37.5%**

Example:

A patient with a diagnosis of depression was seen in the office by her family practice physician. For purposes of our mathematical calculations, let's assume Medicare allowed \$100 for the service. The break out would be as follows.

Medicare payment: **\$100 x 62.5% payable at 80% = \$50.00**

Patient's portion: **\$100 x 62.5% payable at 20% = \$12.50**

Psyche limit: **\$100 x 37.5% = \$37.50**

The patient would owe a copayment of \$12.50 plus the amount that was held to the psychiatric limit of payment or \$37.50. For psychiatric services, the patient

would be responsible for a total amount of \$50.

The underlying fact of the psychiatric limit of payment is: Medicare will pay 50% of the allowed amount with the patient being responsible for the remaining 50% of the allowed amount.

CODING TIP

To maximize reimbursement, offices should have a complete understanding of the various payment formulas used by carriers with whom they have contact agreements. This knowledge is a vital factor in obtaining correct reimbursement for your services. Remember: "Good collection activity is vital to the health and wealth of your practice."

Do you have a question you would like answered in the Journal MSMA? Send your inquires to Wanda L. Adams, CPC, 3201 Cambridge Drive, Festus, MO 63028. Please include your name and phone number should additional information be required.

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Whitman B. Johnson, III, J.D.

Ten Commandments of Risk Management

When physicians get sued, the first thing they often ask their lawyer is "What could I have done differently?" Unfortunately, at that point in time, it is too late to avoid the suit that has already been filed, but there are some fairly simple steps that can help avoid future litigation. Despite the title, none of these hints is actually written in stone, but carrying them out will reduce the chance that you will find yourself a defendant and also put your lawyer in the best position to defend you if you are ever sued.

1. Thou Shalt Take Care of Yourself.

There are two persons involved in the physician-patient relationship. Although the focus should certainly be on the patient, the physician must realize that unless he takes care of himself, the care he provides to his patient will suffer. A tired or preoccupied doctor loses his focus and makes mistakes that he would never make under normal circumstances. Consequently, you should get enough rest, exercise regularly, and don't drink to excess or abuse drugs. Don't overwork yourself and be sure to take time to be with and enjoy your family. A physician who focuses on his practice to the exclusion of everything else loses that bit of humanity which was the original core of the physician-patient relationship.

You should also realize that your personal life reflects on your work life. Everyone knows at least one physician whose personal life fell apart, followed closely by his practice. If there are personal problems in your life, seek to resolve them immediately. The same is true of any health problems that you may have. Ignoring your own danger signs or neglecting your physical health does neither your patients nor your family any good.

2. Thou Shalt Associate with Good People.

This means everybody that you come into contact with - your partners, your office staff, the nurses in your hospital and your consultants. Each of these people is an important link in the healthcare chain. This chain is only as strong as its weakest link, and any failure in that chain will inevitably be attributed to you. Under Mississippi law, a physician has "a non-delegable duty" to treat the patient through maximum medical recovery. Plaintiffs' attorneys are beginning to argue that this language prevents a physician from absolving himself of responsibility by turning the patient over to another physician or by saying the nurses simply did not call him. Given this, it is vitally important that you be able to trust all of the people who make up the healthcare chain for your patient.

Equally important as the people is the system that you set up. Be sure your office staff has an easy to follow system for such things as no shows, call backs, and physician paging so that both you and your patients are aware of abnormal test results and missed appointments. So many cases of "malpractice" are the simple result of information that somehow never makes it to the physician, but for which he is responsible. In such cases, it is the system that failed, not the doctor. This is something that you can control.

3. Thou Shalt Keep Accurate and Timely Records.

Few medical negligence cases are filed less than a year after the alleged negligence. Given the Mississippi State Supreme Court's liberal interpretation of the statute of limitations, many times cases are not filed until years after the events at issue. Plaintiffs or family members often have very specific recollections (whether they be

real or imagined) of encounters with the physician because to that patient or his family, it was one of the most important things happening in their life. The doctor, however, often times has no specific memory of the treatment, and instead has to rely on his notes. For this reason, these notes need to be detailed, accurate, and timely written or dictated.

Cases that might otherwise be defensible can become impossible to win if the physician has not documented his activities. Office records tend to be woefully inadequate, many times with little to no clinical information. Hospital records, although better, are rarely timed and there are even occasions when physicians visit a patient but write nothing in the chart. Even worse is a dictated discharge summary which somehow is not dictated until several months after discharge or death, at a time when the physician and the hospital have already gotten a request for records. In that case, any favorable information in the note will be viewed as self-serving.

Simply put, if you are going to take the time to provide good patient care, take an extra minute or two to document what you found and what you did. Date and time your note, and be sure you put something in the chart every time you go by to see the patient, even if you see the patient three to four times on a particular day. Finally, dictate your operative notes and discharge summaries as quickly as possible, while things are still fresh on your mind. Make them as detailed as possible, because many times what is not in a note is just as important as what is in the note.

4. Thou Shalt Talk with Your Patient.

Note that this says you should talk with your patient, not to your patient. Doctors are often times in a hurry, especially in the office setting, and tend to talk at the patient as opposed to talking with them. The patient's disease or complaints are probably common to you, but to that patient or patient's family, these complaints are scary. The patient sits in the office, or in the hospital, with a specific complaint, wondering if it is life threatening or trivial. They probably have questions, and may have some complaints that they are not even telling you about. Take the time to discuss with them what is happening to them and answer as many questions as they have.

This is especially true when a particular patient has a complication or their health starts to deteriorate. In situations like that, it is only natural for the doctor to want to avoid the hard questions. However, it is times like these that the questions need to be answered. Dealing openly with the patient and his family, trying to explain any complications or problems that were encountered, may not keep you from being sued, but failing to do that will almost certainly send the family to a lawyer simply to get

answers to questions you wouldn't even let them ask. While the patient's family may only have wanted answers, the lawyer is looking for a specific answer, and it's one that says you made a mistake.

5. Thou Shalt Not Criticize Previous Physicians.

This commandment comes with an exception - if you truly believe a fellow physician has been negligent, then you should be willing to criticize him. The problem is very few subsequent treating physicians know all of the facts upon which the previous doctor was acting, and patients are notoriously bad historians, especially when prior therapy has been unsuccessful. Further, because no one wants to believe that anything bad could happen to him or his family, these patients come to you looking for you to tell them that the previous doctor did something wrong. Consequently, what you consider to be a non-committal response ("I don't use that drug", "Are you sure he didn't run that test?" or even "Hmm") will be interpreted by the patient or family as your criticism of the previous doctor. Since you are now seeing the patient at a different time and with more knowledge, it is best to explain to the patient that you want to concentrate on getting him well now, with knowledge of subsequent events.

6. Thou Shalt Not Exceed Your Capabilities.

One of Clint Eastwood's mantras in the Dirty Harry series was "a man's got to know his limitations." This is especially true in medicine. Nothing can get a physician in trouble faster than trying a procedure he has little experience with, or attempting to treat a patient who has developed a problem just outside of his specialty. A physician who ventures off into another specialty will be held to the standard of care expected of persons actually practicing in that specialty. Given the easy availability of specialties of all types and the ease of transportation which can facilitate a patient anywhere in the state seeing any specialist, trying to do more than you should is fraught with danger.

7. Thou Shalt Listen to Others.

Physicians generally pay attention to comments by other physicians about the care of a particular patient. However, less attention is paid to comments by persons who have more contact with the patient or know more about the patient than these consultants ever could- hospital nurses and the patient or patient's family. Everything that any of these people say should be thoughtfully considered, not just dismissed as being comments from "only the nurse" or "only the patient".

No doctor can deny that hospital nurses are his "eyes and ears" while he is not there. These nurses are

trained to recognize changes in condition and report them to the physicians. However, for some reasons, physicians tend to give these observations less than their full attention. If a nurse contacts you about a patient, listen and respond. You can rest assured that the nurse is going to document she called you. If a nurse calls a second time, get up and see the patient. A nurse who calls twice is not comfortable about what she is seeing with the patient and is looking for help.

Pay attention to comments by the patient or family members as well. Given the easy access to medical information web sites in this computer age, chances are that your patients have already done a little digging on their own. Patients tend to anticipate the worst, while you have been trained to think horses and not zebras when you hear hoof beats. The problem is even hypochondriacs get sick and develop dread diseases. While you may be right in dismissing a patient's fears 99 times out of a 100, it is the hundredth time where you are wrong and the patient is right that comes to court.

8. Thou Shalt Not Deceive.

The easiest way to turn a defensible case into one that has to be settled is for the physician to do something deceptive such as change records, lie to the patient, or hide some fact that the patient is entitled to know. Just as it is only the guilty party who flees, it's only the guilty physician who acts deceptively. Further, such deceptive activity can toll the statute of limitations, allowing the plaintiff to bring suit long after the case would otherwise be barred. Honesty is always the best policy, no matter how much it hurts.

9. Thou Shalt Do Your Best for Your Patient.

This is the overriding commandment that should cover all aspects of your practice. It encompasses everything from keeping up with new technology, drugs, and trends in patient care, to getting up in the middle of the night when a nurse calls, and even to delaying a planned trip when a patient you operated on has not really recovered. Although the standard of care is based on what is expected of a "reasonably prudent, minimally competent" physician, no one wants to be treated by someone who is just barely passable.

As a rule, physicians are intelligent, well trained, and financially secure. To whom much is given, much is expected, and a jury who does not believe you have done your best is not going to be willing to overlook even minor mistakes. On the other hand, if you can convince the jury that you were doing your best, they will be prone to forgive decisions that in hindsight may have been obvious mistakes. Perhaps more importantly, if you know you have done your best, then you can look at yourself in

the mirror knowing that even if the jury decides against you, their decision was based on sympathy as opposed to reasoned judgment.

10. Thou Shalt Financially Protect Yourself and Your Family.

This is the selfish commandment. Few people realize the time, effort and sacrifices that went into your becoming a physician. All the jury may see is a horribly injured patient and a presumably wealthy physician. One large adverse verdict, especially in today's "Who Wants to Be a Millionaire" society, could essentially wipe out your entire life's work.

Consequently, you need to insure yourself well. Twenty-five years ago, \$100,000 policies were common place. Now, \$1 million liability policies are the norm, and may not even be sufficient. Although you should talk with your own insurance carrier about appropriate limits, limits of at least \$3 million are probably wise except for the specialties of obstetrics, anesthesiology, and neurosurgery which need even higher limits.

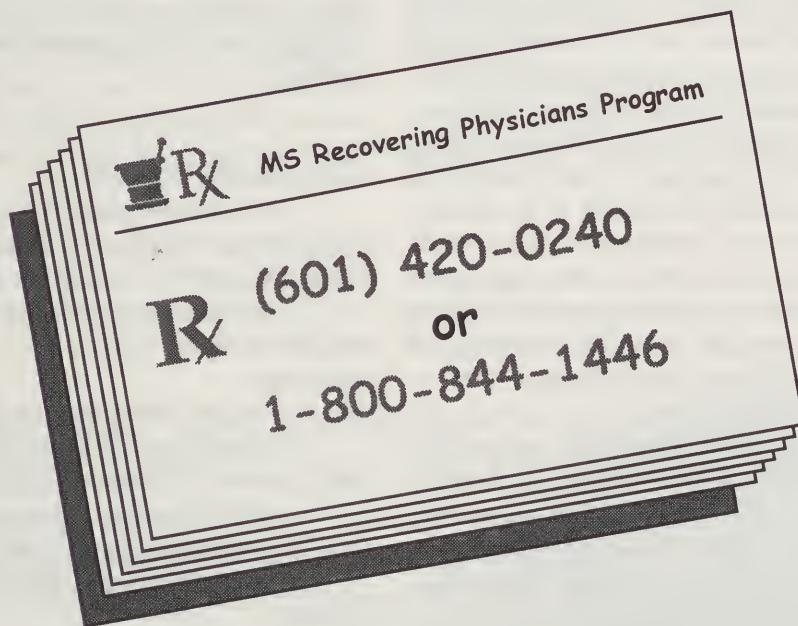
Understand that insurance provides several different functions. Insurance protects you when you make a mistake and someone is injured. However, even more importantly, insurance protects you when you haven't made a mistake, but the patient believes you have and sues you. Your insurance carrier will hire an attorney to defend you and also protect you up to the amount of your limits in case the jury finds against you. That peace of mind is well worth the premium you pay.

In today's litigious society, bad outcomes are often equated with physician negligence. Despite tremendous technological advances, medicine still remains an art. Most of these ten suggestions are aimed at the human side of the practice of medicine, since that is one thing that a physician can control. It is also the most inexact. While there is nothing any physician can do which will guarantee he will not be sued, incorporating these ten commandments into your practice will reduce the chance of suit, as well as make any case that is filed ultimately more defensible.

Mr. Whitman B. Johnson, III is an attorney with the Jackson law firm of Currie, Johnson, Griffin, Gaines & Myers, P.A. The majority of his practice involves defending physicians and other medical care providers, which he has been doing since shortly after his graduation from the University of Mississippi School of Law in 1979. He is also the son of former Mississippi State Medical Association President Dr. Whitman B. Johnson, Jr. of Clarksdale, Mississippi.

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MSMA Joins Medem to Provide Members and their Patients with Authoritative and Secure Online Information and Communications

Mississippi State Medical Association (MSMA) announces it has joined Medem, the e-health network founded by the nation's leading medical specialty societies and the American Medical Association (AMA), adding to its growing roster of leading medical societies.

MSMA is the second state medical association to partner with Medem in the last year. It is anticipated that several other societies will join MSMA in the Medem network in the next few months and deliver both customizable physician Web sites and integrated secure e-mail to their members. A recently released Medem national survey of physicians identified a doubling of physician Web sites and a tripling of physician office to patient e-mail use in the past year.

"Our partnership with Medem offers our member physicians an exciting opportunity to build and improve upon their patient relationships," said Bill Roberts, MSMA Executive Director. "Medem's unique services will be a major tool for our members, especially those rural doctors with an expansive patient base."

Medem's partnership with MSMA is beneficial to both the physician and the society, enabling its approximately 2,600 members in active medical practice - more than half of whom are family physicians - to enhance their practices' exposure online, and service and expand their patient base. In turn, MSMA will be able to provide its members with electronic access to the most current and credible clinical information along with secure e-mail for use in their individual practice Web sites.

"We are delighted that the Mississippi State Medical Association has joined the Medem network," said H. Dunbar Hoskins Jr., MD, Chair of Medem's Board of Directors and Executive Vice President of the American Academy of Ophthalmology. "Together we will advance the goal of offering patients access to the nation's most trusted and credible healthcare content as well as enhanced and convenient online physician-patient communication."

In addition to the other personal and professional medical practice services and benefits MSMA offers, this affiliation will offer member the following free online services:

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About Medem

Established in October 1999 by the nation's medical societies including the AMA, Medem's rapidly expanding network already represents more than two-thirds of American physicians. Medem is building the premier secure patient-physician network featuring the trusted

clinical content of America's leading medical societies and direct patient access to their own physician's Web site.

Medem was founded by the American Academy of Ophthalmology; the American Academy of Pediatrics; the American College of Allergy, Asthma and Immunology; the American College of Obstetricians and Gynecologists; the American Medical Association; the American Psychiatric Association and the American Society of Plastic Surgeons. Among the newest societies to join the Medem network are the American Association of Neurological Surgeons, the American College of Occupational and Environmental Medicine, the American College of Preventive Medicine, Michigan State Medical Society; and, beginning in this month, Mississippi State Medical Association.

For more information call Cheya Pope at (415) 591-5939 or Karen Evers at (601) 853-6733 or visit the company's Web site at www.medem.com.

W

HEN YOU NEED TO BE SEVERAL PLACES AT ONCE,
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The frantic pace of everyday life doesn't leave a lot of time to get to the bank. No problem... if you rely on the convenience of one of the state's largest banking networks. Trustmark has more locations in the places where you need us most. We have Trustmark Express ATMs throughout the state. And 130,000 ATMs around the world through our GulfNet and CIRRUS® affiliations. Plus, Trustmark's Express Check debit card gives you purchasing power wherever MasterCard® is accepted, letting you pay by check without writing one. So, next time you're worried about getting to the bank, relax. Whether you're headed ACROSS TOWN or ACROSS THE STATE, there's one bank you can trust to be there: TRUSTMARK.



372N06



Do You Know What Info is on the Web About You?

Physician profiling may have taken the information highway to your front door. **Searchpointe.com** is a Web site where consumers can get information about any doctor licensed in the United States.

Unlike many state databases, this repository contains information from every state in which a doctor has practiced, not just the state in which a physician is currently practicing. **Searchpointe.com** hails itself as "The Internet's most comprehensive source of background and credential verification information."

The doctor search component of the Web site "combines the data from all 50 states to provide a single, nationwide source for physician education, license and disciplinary action data." The site provides a basic profile for free and charges a fee for a physician license and sanction report. There is even an option to pay more to receive an alert anytime the doctor's report is updated.

There is concern the database may contain inaccurate data. We are not promoting use of this site, but we want to make you aware that it exists. Information about you is housed on this site - every physician in the U.S. is tracked. You may want to visit the site to verify the accuracy of your profile www.searchpointe.com.

Other "doctor search" sites worth mentioning include the following:

- **A Second Opinion Medical Information Services, Your Physician Background Verification Specialist** (<http://members.spree.com/angeleye>), claims to be "your complete medical information resource site. Best doctor/hospital searches -Medical treatment option - Physician misconduct searches and much more. Physician Background Search - Disciplinary Action search with Education background and past lawsuits." This site charges \$135.00 per four States and notes that if a large amount of lawsuits are found, an additional fee will be

added and the search may take longer than normal. Due to the cost of obtaining the lawsuits, some state searches may cost more than \$135.00 for lawsuits.

- **HealthStreet** (<http://www.healthstreet.com>) says it "provides detailed information on virtually every practicing physician in America. Search by location, specialty, sub-specialty, hospital affiliations, health plans, languages spoken and other criteria." Information is provided about the private company but does not tell where or how they gather their information. Again, you may want to check its basic facts about you for accuracy. If the data is inaccurate, the site allows you to click and e-mail your update.

- **Doctorpage.com - Doctor & Physician Directory** (<http://www.doctorpage.com>) is a site to "search for a doctor by name, location, or medical speciality, or register to be added to the database."

- **Medi-Net** (<http://www.askmedi.com>) claims it "is a one-of-a-kind information delivery service that provides background information on every physician licensed to practice in the United States. Now with just one call, you can get information that will help you make informed choices concerning your healthcare." While Medi-Net gathers its data from the American Medical Association's Physician Master File they also consult the Drug Enforcement Administration's (D.E.A.) list of sanctioned physicians, the Food and Drug Administration's (F.D.A.) list of sanctioned physicians, the Department of Health and Human Services' database of physicians that have been convicted of violations such as Medicare or Medicaid fraud and records from State Medical Disciplinary Boards of disciplinary actions taken by them against physicians. This information is gathered from every State Medical Board in the United States and Puerto Rico. In most cases, these board records of

disciplinary actions include details of the nature of the charges brought against a specific physician, the time period in question, and the action or actions recommended or taken by the board. Medi-Net claims "each report is verified for disciplinary actions from 70 sources. The information in these files is updated each time an agency of the federal government, or a state agency releases for publication findings or minutes of disciplinary hearings. The time period between updates varies from state to state and agency to agency, with some publishing updates as actions are taken, some on a weekly or monthly basis, and others as little as once per year." They also sell their reports on physicians.

While the MSMA is not insinuating these are necessarily bad Web sites, we are encouraging you to question the accuracy of the information which may be contained on these Web sites about you. We hope our new partnership with **MEDEM** (<http://www.medem.com>), established by physicians for physicians, (*see related article pp. 736-737*), will make the Internet a credible resource for your patients and a valuable business tool for you by putting your practice online with leading medical societies behind you.

Seeking Old Issues of Mississippi Doctor

Do you have old issues of the *Mississippi Doctor*? If so, would you be willing to donate them to complete bound volumes for the MSMA library?

The *JOURNAL of the Mississippi State Medical Association* was first published in 1960 and the library has them in bound volumes from then to present. It would be great to have these *Mississippi Doctor* publications bound as they help document the history of our association and illustrate the progression of modern medicine. Our current inventory includes almost seven volumes; however, we are in search of the following issues:

1940	May-December	1954	July, November
1941	February-December	1955	August
1942	January-June, October	1956	January
1946	November	1959	March
1947	March, May		
1948	June, September, November		

If anyone has these missing issues and would be willing to donate them please contact Karen Evers, (601) 853-6733 or toll-free 1-800-898-0251.



Calling All Mississippi Physician/Photographers

SEEKING PHOTOS TAKEN BY MISSISSIPPI PHYSICIANS
FOR YR. 2001 *JOURNAL* COVERS

● Load your camera. Shoot landscapes, people, animals, or anything else you can capture on film. Photos of subjects indicative of Mississippi will be given the highest consideration. Photos of original paintings, drawings and artwork are also acceptable.

● The Committee on Publications will judge the entries on the merits of quality, composition, originality and appropriateness to the *JOURNAL MSMA* and select the best cover photos. All photos selected require the photographer and subjects contained therein to release "permission to reprint" and "publicize on the *JOURNAL MSMA* World Wide Web site".

● Specifications: Color slides (slides must have photo accompanying) and photos only. Size: approximately 5 x 7" or 8 x 10". Vertical format photos are strongly preferred. DEADLINE: October 27, 2000

Send entries with a brief description of the subject, as well as of yourself, to:

Karen Evers, managing editor

JOURNAL MSMA

P.O. Box 2548, Ridgeland, MS 39158-2548

or deliver to MSMA headquarters:

408 West Parkway Place

Ridgeland, MS 39157

For more information: contact Karen Evers at (800) 898-0251 or (601) 853-6733



Candace E. Keller, M.D., M.P.H. The President's Page

Balance

*“But yield who will to their separation
My object in living is to unite
My avocation and my vocation
As my two eyes make one in sight
Only where love and need are one,
And the work is play for mortal stakes
Is the deed ever really done
For Heaven and the future's sakes.”*

— Robert Frost

“W

hether it be a gymnast on the balance beam, Tiger Woods on the golf course, or a physician on the front lines of medicine, putting it all together mentally, physically, and emotionally is an intricate balancing act. As physicians, we all face the daily challenges of balancing a demanding career, a cherished family, and our own health. Each of us could tell the story of grappling with intense, and often competing demands for our time, attention, and energy. To achieve the state of internal calm and power needed to live and perform at our highest level requires balance.

Medicine tends to seek perfectionists and our training further cultivates that. Our work largely defines who we are. While this may help us professionally, it often takes its toll on our personal lives. When work isn't going perfectly, we tend to attack our self-worth, work harder to compensate, and fail to take time to rejuvenate. Consequently, situations often go from bad to worse with seemingly no light at the end of the tunnel.

Despite the high calling of our chosen medical profession, we are still human beings. It is better to acknowledge the challenges we face and seek the proper balance we need before a negative life event – be it illness, problems at home, or on the job – occurs, rather than after a lifestyle change has been forced upon us. The more complex our world becomes, the more likely we are to move off track. Time, not money, is the truest indicator of one's priorities and an excellent measure of life balance.

In order to sustain our many positive contributions over a long period of time, we must reinforce basic values that cut across all elements of our lives, both professional and personal. We must invest time in those basic values and in revitalizing relationships, protect our families, and frequently refocus our attention. We sometimes must place limits on our spheres of interest, in order to proceed at a realistic pace and successfully negotiate the obstacles that come our way.

Now that summer has come and gone and we once again turn our attention to school and work, let us take time to remember the precious gift of life we've been given. Take a little time to smell the roses as an integral part of each and every day.

Editorials

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XLI, NUMBER 9
SEPTEMBER 2000

HANGIN' IN THERE

I'd be a fool to stop now. After all, I still have a full head of hair, I've not experienced any change in bowel habits, I can identify (for better or worse) Bill Clinton as our current president, and I haven't gotten pregnant.

As a matter of fact, except for discovering that I'd been taking placebo Bufferin for the first five years, my 18 years as a guinea pig for medical science have been uneventful. Since 1982, I have been a participant in Harvard Medical School's Physicians' Health Study (PHS).

Although begun to answer several specific questions regarding the prevention of cancer and cardiovascular disease, PHS evolved into an even more complex and exciting study of many aspects of men's health. New hypotheses about conditions as varied as prostate and other cancers, cardiovascular disease, age-related eye disease, hypertension, kidney and liver disease, and cognitive function are being examined. The original PHS has undergone a metamorphosis from a completed randomized clinical trial into one of the longer observational cohort studies of men's health issues.

So far, PHS has generated more than 100 articles in major medical journals. The range of topics is extraordinarily broad--from the widely cited reports in the New England Journal of Medicine on the effects of aspirin and Beta carotene on cardiovascular and cancer to reports on circadian rhythms in the onset of myocardial infarction, the value of the ratio of total cholesterol to HDL cholesterol in determining cardiovascular risk, the association between risk of cardiovascular disease and markers such as serum homocysteine, and the link between physical activity and risk of colon cancer and stroke. A new randomized trial called Physicians' Health Study II will include about 750 old hands and an equal number of new volunteers recruited by letter from a list of all potentially eligible male physicians provided by the American Medical Association. The double-blind, placebo-controlled study will investigate Vitamin E on alternate days, Vitamin C every day, Beta carotene on alternate days, and a multivitamin every day. These agents were selected because all four have been identified as potentially effective in preventing cancer, cardiovascular, or age-related eye disease.

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal MSMA.

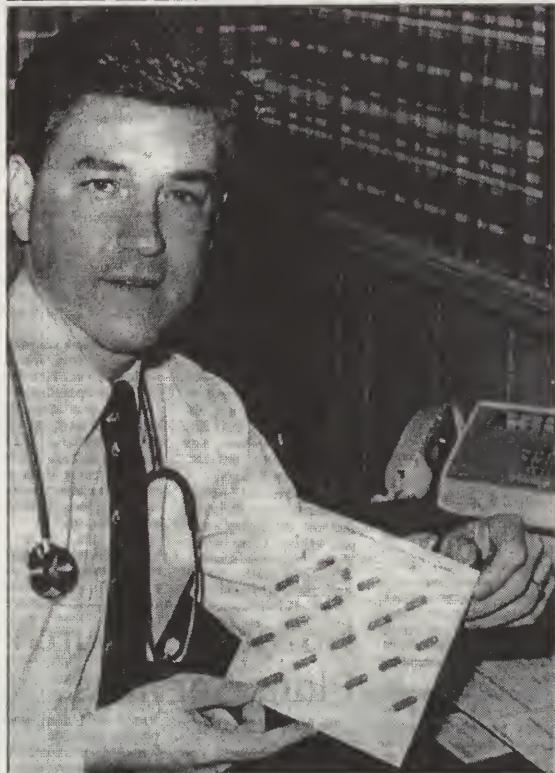
Beginning in 2000, PHS II participants can help answer important questions about the prevention of aging-related memory loss. Men who are age 65 or older will be given the option of a 10-minute telephone interview consisting of several standard memory tests. The goal is to understand if antioxidants, particularly Vitamin E, play a role in preventing memory loss over time. Two follow-up interviews will be conducted at two-year intervals to evaluate any changes in memory. "Delaying memory loss by even a small amount would have a significant impact on our rapidly aging society," says epidemiologist Francine Grodatein, sub-study director.

We original PHS volunteers have been characterized as committed and conscientious (not to mention humble!). Even the word "extraordinary" has been used in describing our returning questionnaires to update our health and medical conditions. My life is now an open book. Everything from baseline blood pressures and cholesterol levels to detailed data on lifestyle variables such as smoking, alcohol consumption, exercise, headache frequency, and use of a range of medications has been compiled.

I still could have sworn that those pills were Bufferin. My headaches even went away.

— *Stanley Hartness, M.D.
Associate Editor*

16 The Star Herald, Kosciusko, Miss., Jan. 6, 1983



Dr. Stanley Hartness With Trial Pills

City Doctor Participates In Harvard Research Job

By BETH SHAW

The Harvard Medical School is conducting a four-year drug research program using 27,000 physicians across the United States. Dr. Stanley Hartness of Kosciusko is one of the many doctors participating in the drug survey.

The medical school sent questionnaires to doctors across the nation and Hartness received one. The surveyors were looking for healthy physicians and Hartness was chosen to participate after completing his form.

The survey is based on the testing of two drugs to see if they will prevent heart attacks and cancer. For the next four years, each doctor will take one aspirin tablet and one capsule of beta carotene on alternate mornings.

Researchers are testing to see if long-range usage of aspirin will prevent heart attacks and if the same dosage of beta carotene, a compound found in yellow vegetables, will prevent cancer.

The Harvard school sends Hartness the drugs in packages designed to last for to last for six months at a time.

"This type of survey lets the public know that we physicians are interested enough and care enough to make guinea pigs of ourselves in order to further medical science," Hartness said.

During the four-year study, the medical school will follow the "guinea pigs" with thorough, periodic questionnaires asking questions such as "Do you feel any differently than before using the drugs?"; "Have you developed any heart problems since using the drugs?"; "Have you developed any type of cancer?".

Hartness has been a participant in the survey for several months and said he will continue in the drug study program throughout its entirety.

TOBACCO-PROBLEMS? PROMISE?

Those of you who did not attend the Tobacco Summit on May 23 and 24 missed a historic event as well as an educational one. As a surgeon, I read years ago the warnings put out by the late great surgeon Dr. Alton Oschner. These were basically ignored and the dangers of tobacco seemed relatively insignificant to most of us in the field of medicine. However, in the last twenty years through much research and investigation we have become increasingly aware that tobacco is as addicting as cocaine and alcohol. Not only is it addicting, but it is the leading cause of preventable death in the United States. In our country we frequently ignore social health problems and take the attitude that people can die as they so choose. However, as protectors of the health of the citizens of Mississippi we must become proactive and work with our State Board of Health, the Partnership for a Healthy Mississippi, and the IQH to make our youth and those adults who use tobacco more aware of its dangers.

Our state has been gathering data along with several other states for the past three years. The Center for Disease Control has put these together and come up with some frightening statistics. Each day more than 3,000 young people across this country become daily smokers, and of all people younger than 18 it is estimated that five million will die prematurely from smoking-related illnesses. In our state alone in 1999 approximately 42% of our young people in grades 9-12 in both public and private schools used at least one tobacco product. Even more alarming is the fact that 30% of middle school youth in grades 6-8 used tobacco products. These alarming facts caused a historic piece of legislation to be passed and signed into law by our governor on May 23 of this year. This bill prohibits the use of tobacco products on school property by both students and adults. I would be remiss if I did not mention the fact that the youth of our state were instrumental in the passage of this legislation. I should also mention that the son of Dr. Tim Alford was the originator of this idea and his father challenged all of us to make it reality.

Legislation is not the real answer to the problem, the real answer lies in education and cessation. We must begin by educating our children K-12 to the real problems, associated with tobacco use. We must inform them not only of the physiological and psychological problems but of the social problems that tobacco use causes. Statistically we know that only 10% of smokers start after the age of 18. We must not forget those who are addicted to tobacco, for cessation is indeed a difficult process. A cocaine user just recently told me that it was easier to quit cocaine than tobacco. Besides what we as physicians can offer there is additional help. The tobacco quit line is sponsored by IQH. This is a confidential support line designated to help those who want to become tobacco free. Each caller talks to a Masters level counselor who has been trained in tobacco cessation. There is no charge for this service and it is available from 8:00 a.m. until 7:00 p.m., Monday through Friday. The number to call is: 1-877-4US2ACT.

REMEMBER, WE MUST ALL PULL AND ACT TOGETHER IF WE WANT HEALTHIER LIVES FOR OUR CHILDREN AND GRANDCHILDREN. 1-877-4US2ACT.

—W. Briggs Hopson, Jr., M.D.
MSMA Immediate Past-President

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal. MSMA



Wand of Aesculapius

Looking Back: Acute Hydramnios, Complicated With Ascites; Report Of A Case

Selected and edited by Lucius Lampton, MD, Associate Editor

[This month, we look back to a report published in the *Transactions of the Mississippi State Medical Association*, which was presented at the Forty-fourth Annual Session, held at Jackson on April 11-13, 1911. It was written by the famed public health champion, Dr. Felix Joel Underwood (1882-1959). This "Man who saved a million lives" was then still practicing medicine at Nettleton on the Lee County/Monroe County line in northeast Mississippi. He would soon be elected president of the MSMA in 1919 and later made his mark as the longtime executive officer and secretary of the Mississippi State Board of Health. A portrait of this great man is being prepared for the Mississippi Hall of Fame.

"Looking Back" is a monthly feature of the Journal. Any doctors with old volumes of these publications are invited to submit articles from them for publication in "Looking Back."]—Ed.

One year ago, after I had stood before this Association and told you about my troubles with abortion cases, and recounted one case of inevitable abortion especially, and a number of you were kind enough to discuss my paper freely, I went home "full to bursting" with obstetrical information, thinking surely I was now complete master of any obstetrical problem that can possibly pop up.

On a certain hot, sultry night of last August this idea left me very suddenly, and I have been very penitent every day since with foreboding of evil.

The case I wish to report, a case of acute hydramnios complicated with ascites, may not be interesting to you, especially the old veterans, but I assure you that it gave me some food for thought.

On the night of August 22nd 1910 I was called to Maria Hogan (negress). She was five and one-half months pregnant, primipara, age twenty. From the history that I was able to get, her pregnancy had been uneventful up to about fifteen days previous to this time, when the abdominal distention was very conspicuous. When I was called she was large enough for full term. She was greatly depressed, had an irregular, quick pulse, dyspnoea and temperature of 102 degrees F. Physical examination revealed ascites. She was not very fleshy and fluctuation could be plainly detected on both sides and above the uterus.

I decided upon a course of medication, which I proceeded to prescribe, the treatment to last twenty-four hours. Seven hours after I saw her I was called by 'phone in great haste, the party at the 'phone telling me that she was sinking. Upon my arrival her sister said that she had been threatened with heart failure for an hour or two. I found serious cardiac disturbance and her abdomen had enlarged to fierce proportions. I asked for consultation, and that quick, and while waiting for his arrival I decided that I would try paracentesis for temporary relief; but this was a failure. After the consulting physician arrived we decided to at once try the induction of abortion. I informed the husband of the gravity of the situation and he and his mother-in-law asked us to do what we thought best.

After she was anesthetized, the vulva, vagina, and cervix were cleansed and disinfected. I gradually dilated the cervix to the size of a silver half-dollar, ruptured the membrane and permitted the discharge of one gallon of water slowly. This gave great relief; her heart beat stronger and lost its wavering irregularity; her dyspnea disappeared

and all symptoms pointed to improvement. She was allowed to come out from under the anesthetic, for she had begun having pains of a bearing-down nature. In four hours the uterus emptied itself of all contents, with no untoward symptoms following. The child was dead. Mother's recovery was complete.

I examined the foetus, umbilical veins and placenta, and found nothing to clear up the cause of trouble. Family history very good. Don't think she had syphilis. There were no lesions of the heart, blood vessels, liver or kidneys. There was very little oedema of the extremities. No diabetes, no albuminuria. When I called the next day her mother told me that her husband had "kicked her in the bowels" about two weeks prior to the trouble, and I then thought that the kick had caused an inflammation of the amnion itself, which caused all my trouble.

I report this case to you for what it is worth, and will welcome criticism.

—F. J. Underwood, M. D., Nettleton

Transactions of the MSMA, 1911, pages 155-156

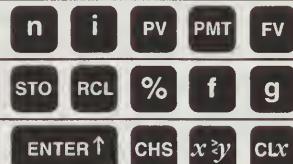
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Online Calendar allows you keep up with what is going on when and post your special events.
Online CME allows you to register and obtain continuing medical education credits via the internet.

The screenshot shows the homepage of the MSMA Online website. At the top, there is a Microsoft Internet Explorer toolbar with buttons for Stop, Back, Forward, Refresh, Home, Search, Favorites, and History. The address bar shows the URL <http://www.msmaonline.com>. The main header features the MSMA logo and the text "MSMA Online" and "Official Website of the Mississippi State Medical Association". Below the header, there is a banner for the "Grand Opening of the MSMA website". The page content includes links to "MSMA News", "MSMA Events", "MSMA Committees", "MSMA Sections", "MSMA Resources", "MSMA Board of Ethics & Rules", and "MSMA Officers". There is also a "Feedback" link. The bottom of the page has a footer with links to "About MSMA", "MSMA News", "MSMA Events", "MSMA Committees", "MSMA Sections", "MSMA Resources", "MSMA Board of Ethics & Rules", "MSMA Officers", and "Feedback".

Online Directory

allows you to directly connect with other members.

Online Links

allows you to connect with related organizations.

Online Membership

allows you to process your application or renewal and payment via the internet.

Online Messageboard

allows you to post your message, communicate with other members, MSMA officers and staff.

Online Physician Locator

allows you to locate other members by specialty and by location.

This and more coming soon....

“Liability Issues: Safeguards for Clinical Drug Trials”

Physicians are frequently requested by drugs companies, or sponsors, to be clinical investigators in drug studies. Performing clinical drug research can be personally and financially rewarding for the physician. However, a physician considering involvement as a clinical investigator should carefully review the regulatory, financial and contractual aspects of clinical drug research.

When considering whether to participate as an investigator in a clinical drug trial, the physician should be aware that this area is regulated significantly by the Food and Drug Administration. The investigator is responsible for (1) insuring that the investigation is conducted according to the investigation protocol and applicable regulations, (2) protecting the rights, safety and welfare of subjects under the investigator's care, (3) control of drugs under investigation, and (4) obtaining the informed consent of each subject to whom the drug is to be administered.

Do not automatically assume that the study is worth doing. Make sure to review the study protocol and budget before proceeding forward. The clinical investigator should analyze issues regarding study time frame, budget restraints, patient recruitment, feasibility of protocol, and staff availability.

Documents commonly used in clinical drug trials include the study protocol, clinical study agreement, indemnification agreement, confidentiality agreement, Statement of Investigator (FDA form), and subject consent form.

Sometimes the sponsor's study agreement (or contract) is the last thing the physician receives. It is important that you review all agreements taking note of specific commitments it is making to you and your patients or that it is holding you to.

Is there an enrollment completion deadline date? Is there a contracted number of patients documented in the agreement or in the attached sponsor budget? Is this the number you were told or led to believe? Is this a manageable number for your practice?

Are screen-failed patients compensated by the sponsor? Sometimes this is not addressed in the sponsor's agreement or the sponsor's budget. Always know how and what the sponsor will pay and what screen fail rate

you expect to see.

Is the sponsor paying for all patient procedures required for the study? If all required study procedures are not paid for by the sponsor, make sure the patient consent describes this. Is the sponsor paying for medical expenses resulting from study-related adverse events? This is usually stated in both the agreement and the patient consent form. These statements should be clear and not in conflict with one another.

When will the first payment be made by the sponsor? Are payments frequent enough, based on your estimation, of study activity to pay your bills? As with any third-party payor, there may be significant time delays in payments based upon the sponsor's receipt and processing of your forms.

The agreement normally contains indemnification provisions which you should carefully review. The sponsor should indemnify you and your clinic for any claim or suit relating to injuries arising from the administration of the drug study. The sponsor will not normally indemnify you for any claim or suit attributable to your negligence or failure to adhere to the study protocol. The agreement should not include any provision whereby you agree to indemnify the sponsor. You should confer with your medical malpractice insurer to determine if your policy covers you and your clinic in your role as an investigator in the drug study. That policy may not cover any written indemnifications made by you.

The termination provisions of the agreement should allow you to terminate your involvement in the study in the event of a material breach of the contract by the sponsor, or if you believe termination is necessary to protect the study subjects.

If you carefully analyze the regulatory, financial and contractual aspects of a proposed clinical drug study, you can create an additional source of income and find personal satisfaction in contributing to the development of new drug treatments.

— *Robert M. Jones, J.D.
Montgomery, McGraw, Collins, Jones,
Cowan & Hembree, PLLC*

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Preoperative Exposure to Calcium Channel Blockers Suggests Increased Blood Product Use Following Cardiac Surgery

George Mychaskiw, II, D.O. et al.

A bstract

Purpose

In this study the authors reviewed the medical records of a random sample of patients undergoing coronary artery bypass grafting (CABG) during the preceding ten years at University Medical Center. The purpose of this study was to evaluate the impact of exposure to calcium channel blockers (CCB's) on blood product use following cardiopulmonary bypass (CPB).

Methods

Design: Retrospective medical record review.

Setting: University hospital.

Participants: 527 patients undergoing CABG or re-do CABG.

Interventions: The medical records of approximately 50% of patients undergoing CABG or re-do CABG at University Medical Center between 1988 and 1998 were randomly selected by the medical records librarian for review. Preoperative medications, bypass time and temperature, and blood product use were recorded.

Results

Of the 527 patients studied, 309 (59%) had no exposure to CCB's. 218 (41%) were on CCB's at the time of admission. Patients who were on CCB's had an average 12.5 (\pm 1.0) blood product units transfused fol-

lowing bypass whereas those not on CCB's had an average 8.7 (\pm 0.6) units transfused ($p<0.001$). Use of packed red blood cells ($p<0.001$), fresh frozen plasma ($p=0.018$) and platelets ($p=0.023$) were each individually significantly increased.

Conclusions

In this study, it appeared that patients exposed to CCB's before cardiac revascularization received significantly more blood products than those who were not exposed to CCB's. Because of the limitations imposed by retrospective studies, further prospective studies are warranted to define the clinical significance of CCB use in the perioperative period.

Key words: Drugs, calcium channel antagonists, cardiac surgery, blood transfusion, retrospective studies, human.

Introduction

Many patients presenting to the operating room for coronary artery bypass grafting (CABG) receive calcium channel blockers as part of their home medication regimen. Recently, a trial using nimodipine, a calcium channel blocker, to ameliorate post bypass neuropsychiatric dysfunction was terminated early because of significantly increased mortality in the

study group.¹ The mortality was related to increased bleeding and complications associated with transfusion and resuscitation. A prohemorrhagic effect of nimodipine was thought to be the cause of this observation.

Calcium channel blockers are frequently used in the medical management of hypertension, angina and cardiac rhythm disturbances. Some calcium channel blockers, such as nimodipine, are used to manage cerebral vasospasm. Additionally, infusions of diltiazem and other calcium channel blockers are commonly used during cardiac surgery to prevent spasm and promote patency of arterial conduits used as bypass grafts.²⁻⁴

This retrospective study compared the usage of blood products following cardiopulmonary bypass in patients who had and had not received calcium channel blockers as part of their preoperative medication regimen.

Methods

Following approval of the university institutional review board for human investigations, the medical records of patients undergoing coronary artery bypass grafting at University Medical Center between 1988 and 1998 were selected at random for retrospective review. The randomization was performed by the medical records librarian who chose records from a list of patient admission numbers assigned to certain CPT codes. During this ten-year interval, the anesthetic, perfusion, and surgical management were fairly consistent, with a standardized set of criteria used for blood product transfusion following bypass (Table 1). Patients undergoing combined coronary revascularization and valve repair or replacement and combined carotid endarterectomy - coronary surgery were excluded. Patients undergoing redo coronary revascularization were included. Total units of blood products administered following separation from cardiopulmonary bypass until discharge from the intensive care unit were recorded. This was further stratified into units of packed red blood cells, fresh frozen plasma, and platelets.

Other data recorded included the patient's age and sex, total time of cardiopulmonary bypass and aortic cross clamping and the lowest temperature reached during the procedure. Preoperative medications and platelet count were recorded, as was the type of procedure, that is, first or redo revascularization.

Chest tube drainage amounts were recorded but were found to be inconsistently documented in the medical records. In many cases no accurate record of the volume of chest tube drainage could be found. Therefore, chest tube drainage was eliminated as a factor for

Postoperative Transfusion Criteria

PRBC's

1. Hematocrit < 26 % in otherwise stable patient post coronary artery bypass.
2. Hemodynamic instability and hematocrit < 30 %.
3. Evidence of ongoing ischemia and hematocrit < 30 %

Platelets

1. Platelet count < 50,000 in otherwise stable patient post coronary bypass
2. Platelet count < 80,000 with evidence of ongoing non-surgical bleeding
3. Ongoing non-surgical bleeding with suspicion of platelet dysfunction, regardless of platelet count.

Fresh Frozen Plasma

1. PT > 20 in otherwise stable patient post coronary bypass.
2. PT > 16 with evidence of ongoing non-surgical bleeding.
3. Known or suspected coagulation factor deficiency.

(Note: above criteria are intended as guidelines only and do not supersede direct clinical evaluation.)

Table 1: Transfusion guidelines currently in use in the University Medical Center.

analysis. Numerous other demographic variables, such as preoperative coagulation parameters, were also inconsistently recorded and could not be included for multivariate logistic analysis.

Data were analyzed for statistical significance using Student's two-tailed t test. P<0.05 was considered to be statistically significant.

Results

A total of 527 charts were reviewed. This number represented approximately 50% of the patients meeting the review criteria for the period. Of these, 309 patients were not exposed to calcium channel blockers in the preoperative period. 218 patients were taking a calcium channel blocker at the time of admission to the hospital. No patient received either intraoperative or postoperative calcium channel blockers during the time interval studied.

The group receiving calcium channel blockers

preoperatively had a significant increase in total blood products transfused: 12.5 ± 1.0 units versus 8.7 ± 0.6 units. The use of packed red blood cells, fresh frozen plasma and platelets were all significantly increased (Table 2).

	No CCBs N = 309	CCBs Used N = 218
Total Units Transfused	8.7 ± 0.6	12.5 ± 1.0 ($p < 0.001$)
PRBC	3.8 ± 0.2	5.2 ± 0.4 ($p < 0.001$)
FFP	2.0 ± 0.1	2.6 ± 0.2 ($p = 0.018$)
Plts	3.0 ± 0.6	4.8 ± 0.5 ($p = 0.023$)

Table 2. Effect of prior therapy with calcium channel blockers on blood product use after open-heart (CABG) surgery. (Mean \pm SEM)

The total time of cardiopulmonary bypass was statistically different between the groups. While the aortic cross-clamp time was not significantly different. Other variables which were not significantly different were the lowest temperature on bypass, the number of patients on heparin or the number undergoing a redo procedure. In the group not exposed to calcium channel blockers there were a greater number of patients on aspirin therapy and a greater number of redo procedures (Table 3). Data were reported as the mean \pm SEM or number (percent).

	No CCBs N = 309	CCBs Used N = 218
XC Time (min)	73.4 ± 1.3	74.7 ± 1.6 (N.S.)
CPB Time (min)	123.0 ± 1.8	132.2 ± 3.2 ($p = 0.009$)
Lowest Temp (°C)	21.6 ± 0.1	21.4 ± 0.1 (N.S.)
Preop Heparin	59 (19.1%)	44 (20.3%)
Preop ASA use	148 (48.1%)	79 (36.2%)
Redo Procedure	17 (5.6%)	8 (3.7%)

Table 3. Patient demographics and procedure characteristics. (Mean \pm SEM or number (percent)).

Discussion

In this study we retrospectively examined the medical records of 527 randomly selected patients who had undergone coronary artery bypass grafting at University Medical Center during the preceding ten years. We found that preoperative use of calcium channel blockers suggested increased blood product transfusion following coronary artery bypass grafting. Neither preoperative heparin, or preoperative aspirin use increased blood product transfusion. The group exposed to calcium channel blockers preoperatively also had a longer

time on bypass. While this finding was statistically significant ($p = 0.009$), a difference of 9 minutes during a total bypass time of greater than 120 minutes in each group is likely clinically insignificant and probably would not account for the increased blood product use.⁵

Calcium channel blockers cause alterations in platelet function. Though the precise mechanism for this action is unclear, calcium channel blockers are known to inhibit platelet aggregation in vitro⁶⁻⁹ possibly related to reduction in the release of thromboxane A2¹⁰⁻¹², antagonism of the calmodulin stimulation of phosphodiesterase^{11, 13}, antagonism of phosphodiesterase directly¹³, inhibition of serotonin uptake¹⁴, or breakdown of cyclic AMP in endothelial cells.^{14, 15} Indirectly, calcium channel blockers may exert a prohemorrhagic effect by increasing red cell deformability.¹⁶ Just as individual calcium channel blockers manifest a variable spectrum of therapeutic response, they may also have varying effects on platelet function and mechanisms for this phenomenon. An example is diltiazem. Diltiazem inhibits platelet aggregation in vitro, but it also has several metabolites, all of which except one decrease platelet aggregation to a greater degree than the parent compound.⁹ This phenomenon is not true with other calcium channel blockers. It has been suggested that some of the beneficial therapeutic effects of calcium channel blockers are their antithrombogenic effects rather than vasodilation.¹⁷

The clinical significance of calcium channel blocker induced platelet dysfunction is unclear. While in healthy human volunteers nimodipine does not alter platelet function¹⁸, diltiazem exposure in animals increases blood loss from standardized incisions¹⁹. It is possible that chronic use of calcium channel blockers, as in patients on medical therapy rather than study volunteers, results in cellular membrane accumulation of calcium channel blocker and more profound effects.¹⁸ Platelet structure and function also differ in older, sicker patients, making them potentially more susceptible to the antiplatelet effects of calcium channel blockers.¹⁸ Additionally, in vivo studies seem to show greater effects of calcium channel blockers on platelet aggregation than in vitro studies.¹⁸

The antiplatelet effects of calcium channel blockers may be synergistic with other antiplatelet agents, as with diltiazem and aspirin.¹² Similarly, interventions that disrupt platelet function may potentiate the effects of calcium channel blockers. In the Thrombolysis in Myocardial Infarction, Phase II Trial, the use of calcium channel blockers significantly increased the risk of intracerebral hemorrhage following thrombolytic

therapy.²⁰ Cardiopulmonary bypass is known to be deleterious to platelet function.²¹ We speculate that bypass induced platelet dysfunction may potentiate the antiplatelet actions of calcium channel blockers.

In this study, the vast majority of patients receiving calcium channel blockers (>80%) were taking diltiazem at the time of admission, with the balance receiving nifedipine. Our results did not stratify the group using calcium channel blockers by specific medications. Also, we have not demonstrated increased blood loss, but rather, increased blood product transfusion associated with preoperative calcium channel blocker use. This study was limited by the inconsistent recording of many variables that may also contribute to increased blood loss following CPB. Although the impact of these variables may be offset somewhat by randomization of the records reviewed, we cannot definitively conclude that calcium channel blocker exposure alone increased blood usage. A prospective collection of data with strict criteria for transfusion and volume replacement is necessary to define completely the impact of calcium channel blocker use on coagulation following CPB. Another limitation of this study is the ten-year period chosen for review. Although the surgical and anesthetic management was fairly consistent at this institution during the period reviewed, changing practice patterns nationwide, including early extubation protocols, use of antifibrinolytics, and improved coagulation monitoring, preclude the generalization of our results. Finally, we were not able to establish and collect outcome data. In the future, prospective, randomized studies are planned to address these issues. Further studies regarding the mechanism of the synergistic actions of cardiopulmonary bypass and calcium channel blockers are also warranted. Prophylaxis against and treatment for this interaction should be investigated, as calcium channel blockers will likely be used in the management of patients with cardiovascular disease for some time to come.

In conclusion, we present a retrospective study of blood product use following coronary artery bypass grafting in patients preoperatively exposed to calcium channel blockers. Our results suggest that preoperative exposure to calcium channel blockers may be a risk factor for increased post bypass transfusion requirements. Further studies are warranted to examine the impact of calcium channel blocker use on coagulation following CPB before definitive statements can be made regarding their safety in cardiac surgery.

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George Mychaskiw II, D.O., Paul Hoehner, M.D., Ahmed Abdel-Aziz, M.D., Claude Brunson, M.D., Luiz G.R. DeLima, M.D., Ahmed E. Badr, M.D. and John H. Eichhorn, M.D. are associated with the University of Mississippi Medical Center.

† **Bobby J. Heath, M.D.**, also a co-author, died August 15, 2000.

Institution: University of Mississippi Medical Center
Departments of Anesthesiology
(Cardiac) and Surgery (Cardiothoracic)
2500 North State Street
Jackson, Mississippi 39216-4505

Address reprint requests to: George Mychaskiw II, D.O., Associate Professor of Anesthesiology, Surgery and Physiology, Director, Cardiac Anesthesiology
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Clonidine Toxicity in an Adolescent Patient

Morris Frederick Gitter, M.D.
Robert Cox, M.D., Ph.D.

A bstract

Clonidine is a central acting α_2 -agonist used primarily as an antihypertensive agent. Recently, it has been used for the treatment of attention deficit hyperactivity disorder in children and adolescents. When taken in excess, it can produce profound CNS depression, apnea, bradycardia and hypotension. A transient period of hypertension can sometimes occur. Treatment is primarily supportive, including respiratory support, atropine for bradycardia, and fluids and dopamine for hypotension. The CNS depression sometimes responds to naloxone. Young children are very sensitive to the toxic effects of clonidine. A case of an 11 year old adolescent who took an overdose of his clonidine is described to illustrate the toxicity of this agent.

Key Words: clonidine, naloxone, overdose

Clonidine is a well-known central α_2 -agonist that is commonly used to treat hypertension in the adult population. Recently it has been used to treat resistant attention deficit hyperactivity disorder (ADHD) and "rage reactions" with variable success (1). Overdose in children has previously been described with ingestion of an adult's medication; however, there has been a sharp increase in the number of cases whereby the child ingested his/her own medication. A case of an eleven year-old autistic child who

ingested a large amount of his own medication and presented with symptomatic bradycardia and hypotension is described.

Case Report

A 11-year-old male patient presented to a community emergency department approximately sixty minutes following the accidental ingestion of 3.5 mg of clonidine (0.1 mg tabs). His past medical history was significant for autism and ADHD, his only medication was clonidine, immunizations were current and he was allergic to penicillin. He had had no surgeries, his family history significant for diabetes and hypertension, he lived at home with his parents and attended special education classes in sixth grade.

The patient's mother found the child unresponsive next to an empty bottle of clonidine. The child had no access to any other drugs or chemicals in the house. The child was pale and lethargic on arrival to the community emergency department with a systolic blood pressure of 60 and a heart rate of 47. Oxygen and a normal saline bolus was immediately administered and increment 0.5 mg boluses of naloxone were given over 15 minutes to a total of 3.5 mg until he became alert. Gastrointestinal decontamination consisted of gastric lavage with an 18 French nasogastric tube with 1 L of 0.9% saline followed by activated charcoal (1 g/kg) with sorbitol. No

pill fragments were observed in the lavage fluid. Sixty minutes after arrival the child was transferred via ambulance with a systolic blood pressure of 120, a heart rate of 100 and a baseline mental status. During the fifteen-minute transport he became unresponsive with a blood pressure of 150/100 and heart rate of 48. The mental status improved after nasotracheal intubation was attempted unsuccessfully by the paramedics.

On arrival to the University of Mississippi Children's Hospital he was somnolent but arousable with vigorous stimulation. His vital signs were temperature, 96.3°F; pulse, 67 beats/minute; blood pressure 165/106; and respiratory rate of 21 breaths/minute. His weight was 68 kg. On physical examination, his pupils were 2 mm and sluggishly responsive to light, his gag reflex was intact and his neurologic examination was nonfocal. His peripheral perfusion was normal with a capillary refill of less than two seconds. The remainder of his examination was within normal limits. Initial laboratory results were normal. An EKG showed sinus bradycardia. A chest x-ray was clear. Three hours after the ingestion he was transferred to the Pediatric Intensive Care Unit for further monitoring. Over the next twelve hours his mental status returned to baseline. His blood pressure ranged from 110-120/60-70; his pulse ranged from 70-90; and his respiratory rate ranged from 20-25. Thirty-six hours after ingestion his blood pressure ranged from 150-160/80-90, his heart rate from 115-135. He was discharged sixty hours after the ingestion with normal blood pressure and pulse and baseline mental status.

Discussion

Clonidine, an imidazoline class antihypertensive, is most commonly used to treat hypertension in adults. It lowers the blood pressure by stimulating central α_2 -adrenergic receptors in the vasomotor center of the medulla oblongata and decreasing sympathetic outflow. In large doses it also produces bradycardia, presumably by stimulation of central α_2 -adrenoceptors and decreasing norepinephrine release. Clonidine also inhibits acetylcholine release at therapeutic doses, resulting in the side effect of a dry mouth. In significant overdoses, a transient period of hypertension may occur. This is felt to occur from stimulation of peripheral α_2 -adrenergic receptors in some blood vessels and perhaps a loss of selectivity and stimulation of peripheral α_1 -receptors. There also appears to be an overlap between central α_2 -adrenergic receptors and opiate receptors. Clonidine has been used to treat opiate withdrawal and naloxone relieves some of the symptoms of clonidine toxicity. The mean elimination half-life of clonidine is 12 – 16 hours.

Clonidine has been used for a myriad of other medical conditions including menopausal flushing, migraine headache, opiate addiction, alcohol addiction, nicotine addiction, Tourette syndrome, attention deficit disorder, obsessive/compulsive disorder and posttraumatic stress disorder. Recently it has been prescribed for children and adolescents for the treatment of attention deficit disorder when hyperactivity is the major component.¹ As a result the number of unintentional overdoses and therapeutic misadventures in children is on the rise.²

The diagnosis of clonidine toxicity is usually made by history and clinical examination. Most signs and symptoms usually appear within one hour after ingestion. The presence of clonidine can be confirmed by serum measurements but the levels do not correlate well with toxicity.³ Serum measurements usually take several days and thus are not helpful in clinical management. Children are especially susceptible to the toxic effects of clonidine, with as little as a single 0.1 mg tablet producing toxic signs and symptoms. The degree of symptoms and the dose ingested are not clearly related, although one study associated moderately serious symptoms (bradycardia and hypotension) with ingestions of more than 0.01 mg/kg and severe symptoms (apnea and respiratory depression) with ingestions of more than 0.02 mg/kg in toddlers.⁴

The toxic effects of clonidine are primarily related to the central nervous system and the cardiovascular system. The neurologic symptoms produced by clonidine include profound CNS depression, lethargy or coma, respiratory depression, miosis, hyporeflexia and hypotonia. These findings closely mimic those of opiate toxicity. Bradycardia and hypotension occur in approximately one-third of children and one-half of adults. Sinus bradycardia and first-degree AV block are the most common rhythms encountered. Hypertension is usually transient and usually signifies a large ingested dose. It may also be precipitated by naloxone administration.

Immediate supportive measures are critical in the management of clonidine toxicity. Up to 12% of children who ingest clonidine require endotracheal intubation.² Naloxone may reverse some of the symptoms of CNS depression; however, it has not prevented the need for endotracheal intubation in severely poisoned patients.² Naloxone is an opiate receptor antagonist and is thought to block clonidine's inhibition of central sympathetic outflow mediated by endogenous opiate release. The recommended dose is 0.1 mg/kg in small children and should be considered if significant CNS depression is present.⁵ The half-life of naloxone is 1 hour, compared with 12 - 16 hours for clonidine; therefore repetitive doses

or continuous infusions may be necessary if an initial response was observed. A paradoxical hypertensive reaction can occur, so naloxone should be administered with caution.

The bradycardia seen in clonidine overdoses typically responds to atropine (0.02 mg/kg up to 1 mg). Hypotension should initially be treated with an isotonic fluid bolus of 20 to 40 mL/kg. If unresponsive, dopamine should be administered to maintain the blood pressure. Hypertension following clonidine ingestion is usually transient and does not usually require treatment. Patients demonstrating significant CNS depression or hypotension should be monitored in an intensive care setting for at least 24 hours.

Since clonidine is rapidly absorbed from the GI tract, gastric emptying has little value. Syrup of ipecac is contraindicated due to the CNS depression caused by clonidine. Gastric lavage has never been shown to be of clinical benefit in overdose patients and may result in a 5%–10% incidence of aspiration pneumonia. Activated charcoal will bind any residual charcoal in the GI tract and has little risk.

Our patient manifested many of the classic signs and symptoms of a clonidine poisoning except for a protracted period of hypertension. This could have been due to excessive use of naloxone or due to agitation while in the intensive care setting. Due to the potentially fatal consequences of inadvertent poisoning, the recent use of clonidine in the pediatric population requires close monitoring. Parents who use clonidine for hypertension should be cautioned to keep it away from children. Finally, physicians should view any clonidine ingestion as potentially life threatening.

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Morris Frederick Gitter, M.D. is a Resident in the Department of Emergency Medicine, University of Mississippi Medical Center.

Robert Cox, M.D., Ph.D. is an Associate Professor, Director, Medical Toxicology Service, Department of Emergency Medicine, University of Mississippi Medical Center.

Reprints:

Robert Cox, MD, Ph.D
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Med Web Info- Developing Rules for the Web

Medical Web Site Ethics

Concern over how health information is presented on the Internet has prompted several groups to step up to the challenge of developing ethics for medical sites.

After DrKoop.com was found to be blurring the lines between editorial content and advertising, Dr. Koop the physician called on the large, U.S.-based health dot.coms to develop a code of ethics.

The result of the call to action by former U.S. Surgeon General C. Everett Koop, MD, was a group representing 20 of these Web sites—called Hi-Ethics for Health Internet Ethics — that released a set of 14 ethical principles May 8. "The goal is simply to earn the trust and respect of the user," said Donald W. Kemper, chair of Hi-Ethics and CEO of Healthwise Inc.

But the Hi-Ethics code isn't the only set of ethical standards developed for medical and health Web sites.

The AMA published its own guidelines in the March 22/29 issue of the *Journal of the American Medical Association*. At the urging of former *JAMA* Editor George D. Lundberg, MD, the Internet Healthcare Coalition's eHealth Ethics Initiative released an international code of ethics May 24. And a Geneva-based nonprofit group developed a code of conduct in 1996 that now has about 3,000 Web sites in 36 countries as subscribers.

So far, this flurry of activity to regulate medicine on the Internet appears to be raising more questions than answers. Chief among them are which code is the "real" code of medical ethics and who will certify that Web sites espousing these principles are in fact complying with them.

Working Together

It is true that the Internet Healthcare Coalition's eHealth effort included members of the Health On the Net Foundation — the Geneva-based group, Hi-Ethics and the AMA. These groups also have talked about coalescing their efforts.

But no one has committed to working toward one common set of ethical principles to address issues including privacy, conflict-of-interest, disclosure and quality of content.

"There's a great deal of talk but so far no action on working toward a single global code," said Tim Nater, executive director of HON Foundation. "That to me is the Holy Grail."

The holders of the ethics codes have not yet decided how to reach this goal. While some suggest adopting one universal code, others want to simply coordinate the current efforts.

"We believe that the eHealth Code of Ethics is really the internationally universal code of expectations for behavior," said Helga E. Rippen, MD, PhD, MPH, co-chair of the eHealth Ethics Initiative and chair of the Internet Healthcare Coalition.

Buoying this claim is the IHC's involvement of 60 diverse representatives in its eHealth summit, and an opportunity for public comment on its draft code.

"I thought it might be an effort by the large dot-coms to do something self-serving," admitted Thomas Murray, PhD, president of The Hastings Center in Garrison, N.Y. "The first surprise was the diversity and intensity of the participants; the second was that they wanted a very rigorous code."

Hi-Ethics members look to the eHealth code as being global in scope and universally applicable. They also see it playing a valuable role as an "aspirational code."

"We always think you should aspire to higher, nobler good, but in actuality some of the things may not be implementable," said Michael J. Rozen, MD, vice president of consumer affairs for WellMed Inc.

Hi-Ethics hopes to work with the Federal Trade Commission to ensure that subscribers adhere to its code, which is focused on U.S. dot-coms. "The Hi-Ethics code is very closely tied to U.S.-based law," Kemper said.

JAMA's guidelines were developed to set the standard for AMA Web sites. But the authors encourage other interested Web sites to use the guidelines voluntarily, and they plan to continue reviewing their use by others. "It's too early in the evolution of the Internet to say that we know exactly what the one set of guidelines should be," said Margaret A. Winker, MD, JAMA deputy editor and director of scientific online resources.

The HON Foundation also isn't going to quickly defer to the eHealth code, which still must be implemented. "Basically, they need subscribers, and the sub-

scribers will need an argument why they should drop the HON code and go with them," Nater said.

Questionable Credibility

Credibility, not surprisingly, is a key issue to those developing ethical standards for medical Web sites.

"We really think that on the health Internet the three most important principles of success are trust, trust, trust," Kemper said. "If the consumer doesn't trust you, they're not going to use the site; if the doctor doesn't trust you, they're not going to send their patients there; and if the regulators don't trust you, they are going to put you out of business."

But the process that's being used to develop that trust doesn't pass muster with at least one bioethicist. Glenn McGee, PhD, a professor of bioethics at the University of Pennsylvania School of Medicine and the director of bioethics.net, sees the Hi-Ethics and IHC efforts as self-inclusive and thus lacking in objectivity. Further, he said, there needs to be research on how consumers perceive information contained on health sites before an effective code can be developed.

"The health world is used to peer review, which is



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an extraordinarily rigorous form of regulation for what kind of information is available to patients or even to colleagues," Dr. McGee said. "Real peer review means thinking about and making rules with regard to conflict of interest, and that's where both of these codes fall pitifully short."

Jerome P. Kassirer, MD, editor-in-chief emeritus of the *New England Journal of Medicine*, finds for-profit medical Web sites problematic. Yet he doesn't think guidelines, while important, are enforceable.

"People are not stupid, and they will gravitate to those Web sites that have respected names," he said. "It's a free-market approach, but in this case the free-market approach is best."

Others also fear that stringent regulations and requirements would violate the democratic principle that governs the Internet. This is one area where the HON code has an advantage. It's short and concise, and can be adopted easily by small Web sites.

The HON code has a second advantage—it, unlike Hi-Ethics and eHealth, already has been implemented. Subscribers, such as Catholic Healthcare West and the Joint Commission on Accreditation of Healthcare Organizations, display an active seal that links users to their registration information.

Hi-Ethics members have agreed to become compliant with their new guidelines by Nov. 1. Though Hi-Ethics intends to maintain control of its code, it plans to choose an independent group to certify whether its members uphold the standards. Because only a hundred or so U.S. sites are expected to meet its standard for membership, oversight like this might be possible.

Given their international scope, the HON and eHealth codes are unlikely to have much success policing adherence. HON Foundation, to some extent, depends on the reporting of violations by Web site users. In contrast, the IHC's eHealth initiative plans to have an independent implementation body in place evaluating sites a year from now. The IHC also plans to establish an ethics board to serve as the "keeper of the code."

"We don't want to necessarily own a code of ethics," Dr. Rippen explained. "What we do want to do is promote a standard."

Medicine's role

Among doctors who have Web sites for their practice are many who say these new standards shouldn't be applied to them.

"Ours is an educational and informational Web site," said Thomas Levin, MD, an interventional cardiologist in Chicago. "The ones that are promoting ecommerce are probably the ones that need to be regulated a little bit

more."

Nancy W. Dickey, MD, editor-in-chief of Medem.com, launched last year by the AMA and several other medical groups, said that because Medem develops physician Web sites it should fall into that same category. "One of the differences is that these are individual physician Web sites generally intended to enhance the existing doctor-patient relationship, differentiating Medem sites from a site that is attempting to establish a relationship where one doesn't exist," she said.

But Alan Greene, MD, the creator of a popular pediatrics Web site that bears his name, said it doesn't take long for people who aren't your patients to land on a doctor's home page.

"When I started my Web site I was just thinking of giving great information to families [I treat], but very quickly other people started coming, and they're people who didn't know me," he said.

In addition, some physicians said current guidelines don't go far enough. They are looking to the AMA to set policy in areas that aren't covered by the *JAMA* guidelines—the practice of medicine online.

Already, state legislatures and medical boards have begun setting standards that are inconsistent with the way medicine is currently practiced offline. Ohio, for example, has a blanket prohibition for Internet prescribing that doesn't take instances of prior physician-patient relationships into consideration.

"We're seeing in many cases a gut reaction to the Viagra-on-the-net-type sites," said Robert Waters, a partner at Arent Fox LLC in Washington, D.C. "If the professional groups and the ehealth telemedicine providers that are reputable and of high caliber don't get involved, the playing field will be determined by the regulator's response to a few bad apples."

Right now, the AMA Council on Ethical and Judicial Affairs appears to be leading the Association's response to the move of the physician-patient relationship online.

"We're trying to evaluate what are the essential elements of the doctor-patient relationship so that we can apply them in the areas where new technology seems to redefine it," said CEJA Chair Herbert Rakatansky, MD. "We want to make sure that we don't shortchange the patients and that they are still getting true professional medical care."

Vida Foubister is on the AMNews staff and covers professional ethics issues. Reprinted with permission, AMNews (July 31, 2000).

Web Sites for Physicians and Patients

URL

AMA	http://www.ama-assn.org/
AMA CME	http://www.ama-assn.org/cmeselec/cmeselec.htm
American Academy of Ophthalmology	http://www.eyenet.org/
American Academy of Pediatrics	http://www.aap.org/
American College of Allergy, Asthma & Immunology	http://allergy.mcg.edu/
American College of Obstetricians and Gynecologists	http://www.acog.org/
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Wed Med Info is a new feature in the JOURNAL MSMA intended to cover new internet innovation and Web sites of interest to Mississippi physicians. The column also highlights features of the MSMA Web site at www.msmaonline.com. Publication of information about Web sites in this column is not to be considered an endorsement of the sites or sponsors, or of any products or services involved or expressions of the views, or official policies of The Mississippi State Medical Association.

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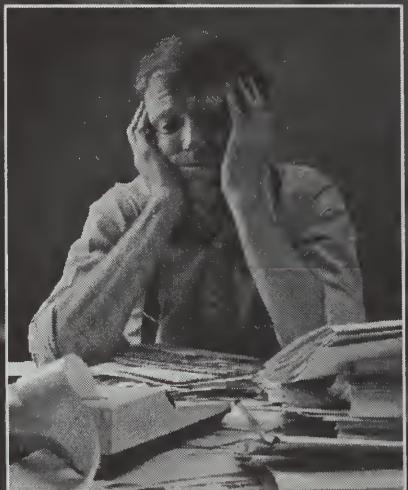
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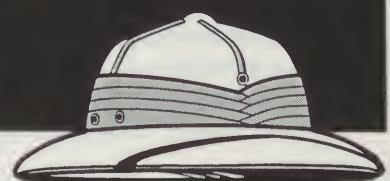


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In Tribute

**Candace E. Keller, M.D., M.P.H.
The President's Page**

“T
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Ecclesiastes 3:1

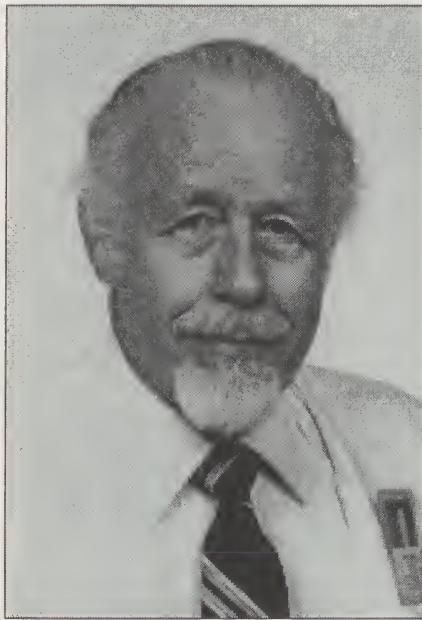
The past few months have brought times of weeping and mourning for the loss of two highly trusted and valued colleagues, David R. Steckler, M.D., and Bobby J. Heath, M.D. Each of them lived exemplary lives of service to their respective families, their communities, their profession, and to the Mississippi State Medical Association. Therefore, this column is written in honor and celebration of their lives.

Dr. Steckler of Natchez was an extraordinary human being. He devoted much of his time, energy, and talent to MSMA over the years, highlighted by his year as President of this organization from 1988 - 1989. He was the guiding force of the Mississippi Physicians Insurance Company as President of its Board of Directors. Although involved in a myriad of activities, his first devotion was always to his family. I shall remember him most for the remarkable way he endured both triumph and tragedy, persevering with indomitable courage despite all odds and obstacles.

Dr. Heath of Jackson was likewise a great man. As Chairman of the Surgery Plenary Section of MSMA's Council on Scientific Assembly, he was instrumental in both planning and moderating the educational sessions of our Annual Meeting for many years. He revived our hearts, not only through his skill as a cardiovascular surgeon, but also through his kind, gentle, giving spirit. He gave himself fully to attending the needs of his patients, family, and friends. He was truly beloved by us all. I shall always remember his winning smile no matter how great the fatigue or personal toll.

For those of us who remain, it shall always seem that their sojourns here were far too short. Let us give honor and tribute not just in word, but in deed by giving ourselves anew to live lives of service to our profession and our fellow man as did they.

A handwritten signature in black ink that reads "Candace". The signature is fluid and cursive, with a large, stylized "C" at the beginning.



Sam Johnson, M.D., 1926-2000

“DR. SAM” REMEMBERED

A 96-year old patient once commented to me that a curse of advancing age is “outliving all my pallbearers.” She joked, but underneath was a sad reality: the longer she lived the more of a stranger she became in her own world. She had outlived all of her friends and even her children. Survival and longevity’s price was the loss of familiar faces and lifelong friends.

The last several years have been hard on those of us with UMC connections. Nancy Tatum, Bob Lampton, Herbert Langford, Carl Evers, Bobby Heath, Verner Holmes, and others have died and their loss certainly diminished the UMC family. The University is a relatively young institution, and many of those who molded it and shaped it did so in the last 40 years.

One of those pillars at UMC was Dr. Samuel B. Johnson, 74, first chairman of the Department of Ophthalmology. On May 12, he drowned in a rafting accident on the Green River in Utah. “Dr. Sam,” as he was known to his residents and students, will be remembered for his kindness, intellect, courage, teaching skills, energy, and extraordinary vigor. Many of his friends and students commented that his death, a rafting accident in his seventh decade of life, revealed much about the way he lived his life: vigorous and courageous engagement with activities and people. “The loss of Dr. Johnson has shocked and saddened all of us at the Medical Center,” commented Dr. Wallace Conerly, UMC vice chancellor and dean. “His legacy at this institution and in the medical community statewide, is enormous— personally and professionally. His good teaching will be passed on through the

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generations."

Dr. Johnson touched the lives of most of the medical school graduates at UMC and he trained most of the ophthalmologists now practicing in Mississippi. As first chairman, he established UMC's ophthalmology department, which is recognized as one of the finest and most competitive in the nation. "I've been working with Dr. Johnson for 20 years," noted Dr. Ching-Jygh Chen, interim ophthalmology chairman and professor of ophthalmology. "He was a very, very kind person — a typical Southern gentleman. He trusted his faculty and allowed us to develop our specialties without interference," Chen remembered. "Faculty members in the department really were blessed by his attitude."

Johnson was a native of Canyon, Texas and he earned his bachelor's of science degree in chemistry at West Texas State College in Canyon and his M.D. at Tulane University in New Orleans. He interned at Knoxville (Tenn.) General Hospital and then took his residency in ophthalmology at Tulane in the New Orleans EENT Hospital. During the Korean War, he was chief of the EENT service at the U.S. Army Hospital in Fort Sills, Okla., and at the U.S. Navy Hospital in Quantico, Va.

Dr. Johnson began practicing ophthalmology in Jackson in 1953. He was the only head of ophthalmology in UMC's history, to date. When UMC opened in 1955, he joined the faculty as chief of the Division of Ophthalmology in the Department of Surgery and chief of the hospital's ophthalmology service. He became chairman of the Department of Ophthalmology in 1987, when the division was elevated to department status, and remained chairman until he stepped down this February. At that time, he was one of the longest serving division or department chairmen at any medical school in the country. He then continued to teach and practice medicine at UMC.

His residents worshipped him, to the point of naming children after him. "My son Sam is named after him," said Dr. Henry J. Sanders of McComb, one of his past residents. Sanders added, "Dr. Sam was loved by his residents. He always had a story he remembered about each resident, and he would recall the story when he saw you in later years. The story always revealed something about the personality of that resident." Another former resident Dr. Fred McMillan of Jackson stated that he owes Dr. Johnson a huge debt "not just for what he had to teach about ophthalmology, but for what he taught about people. He just had fantastic people skills, and I'm grateful to him for instilling in me the importance of knowing people and caring for them." Sanders agreed, and added that Johnson sought to instill in his residents a genuine understanding of the reality of medicine, including its business side. "He made a huge effort to instruct his residents in the complexities of office management and running a business. He was one of the first medical instructors who understood that reality in medicine," he commented.

He was a veteran pilot and an avid outdoorsman. He was vice president of the Flying Physicians' Association International in 1960 and 1964 and president of the local chapter in 1974-75. Sanders reflected that "Dr. Sam" truly enjoyed life: "Each year he would go to the Daytona 500, flying his own airplane!"

My own memories of "Dr. Sam" are as a medical student and as a friend. He impressed me with his vigor and interest in his patient's problems. He had an old typewriter in his treatment room. After examining the patient, his quick fingers would start pecking. He typed his progress notes and any prescriptions before the patient left the room. He was extraordinary in his proficiency.

He was also extraordinary in his friendship. He and my father, the late Dr. Bob Lampton, were longtime friends. He would seek internal medicine counsel from my father and my father would seek ophthalmology counsel from him. They would take duck hunting trips together each year to Louisiana. Even after my father physically declined, "Dr. Sam" would make the necessary arrangements and insist that he go on the trip. He and his daughter patiently assisted my father in and out of the truck and in and out of the duck blind on the last few trips. The trips and "Dr. Sam's" loyal friendship were treasured by my father.

Dr. Johnson served as chairman of the mid-South section of the Association of Research and Vision in Ophthalmology. He served as president of the International Association of Secretaries of Ophthalmology and Otolaryngological Societies; the Mississippi Eye, Ear, Nose and Throat Association; the James H. Allen Residents' Society; and the Louisiana/Mississippi Ophthalmological and Otolaryngological Society.

He served as a consultant to many organizations, including the Research and Development Center of the National Industries for the Blind, the Federal Aviation Administration Southeastern Area, and the Medical Advisory Board of the Eye Bank Association of America. Dr. Johnson was a fellow of the American College of Surgeons, the Academy of Ophthalmology and the Law Science Academy of America. He was the author of many professional papers and contributed a chapter on ophthalmic emergencies to *Rhoads Textbook of Surgery: Fifth Edition*. In 1998,

Dr. Johnson, who was medical director of the Mississippi Lions Eye Bank, was recognized with the Lions Club International Foundation's Melvin Johns Fellowship Award. The award is given to individuals who are committed to the organization's humanitarian objectives.

In the wider, non-medical community, Dr. Johnson was an active deacon in the First Baptist Church. He was named "honorary chairman of the board in perpetuity" of the Mississippi Opera Association. He served the opera as a board member, president and chairman of the board. He sang in the chorus of 20 operas and appeared in several minor roles. He also was a member of the Jackson Symphony Association board of directors and the Jackson Little Theatre board. In recognition of his many volunteer activities, he was elected to the 1999 Goodwill Class of Outstanding Volunteers.

He is survived by his wife, Barbara H. Johnson of Jackson; two daughters, Alice Johnson and Margaret Suddeth, both of Jackson; a son, Lee Johnson of Fort Worth, Texas; a stepson, Hal White of Jackson; five grandchildren; and three sisters. The family asks that memorials be made to the Samuel B. Johnson Professorship in Ophthalmology, c/o Public Affairs, the University of Mississippi Medical Center, 2500 North State, Jackson, 39216; to the Mississippi Animal Rescue League; to the Mississippi Opera Association or a favorite charity.

—Lucius M. Lampton, Associate Editor

[Dr. Lampton would like to thank Leslie Myers, Janis Quinn, and the Public Affairs Department at University Medical Center for assistance with this article.]—Ed.

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Wand of Aesculapius

Looking Back: The Uses and Abuses of Medicine

Selected and edited by Lucius Lampton, MD, Associate Editor

[This month, we look back to a report published in the Transactions of the Mississippi State Medical Association, which was presented at the Forty-second Annual Session, held at Jackson on April 13-15, 1909. It was written by Dr. W. W. Reynolds, a Meridian physician, who was a member of the Lauderdale County Medical Society. His comments in our age of polypharmacy and procedural technology are as pertinent as in his own day. He emphasizes that in practicing the art of medicine we remember our first objective: to do no harm.]—Ed.

You doctors that have been in the practice of medicine for years will appreciate what I am about to say. I have for my subject *materia medica*, and what I want to impress is that I am fearful that we use too many materials of medicine in our respective practices. That is, too much of strong or poisonous drugs when nothing or very little is needed. But you are all aware of the fact that many times we are consulted at the office or sent to the home of the patient and when we make an examination find something trivial and at times nothing abnormal. Now do not expect me to give a thesis on some drug not well known, to get up its habitat, whether it be vegetable, mineral or animal, or get its process of manufacture, the forms of preparation, dose and follow up its therapeutics.

Not that, and do not expect me to take up some older drug and bring out some new use, nor to take up some common or every-day drug, and give something new. Not that; but to try to point out the abuses of those we now have and use.

When we first enter the field of the practice of medicine, we come from college and state boards of health with our minds crammed full of anatomy, physiology, *materia medica*, chemistry, etc., all thrown in indiscriminately, and we are at sea when we are confronted with a patient. We are almost taken off our feet when the patient says "doctor," a name that we have been trying to acclimate all through medical college, but after a few minutes we regain composure and listen to our patient to try to get at his malady. After gaining what information we can from the patient we ask more or less questions trying to bring out other points to get at a diagnosis. After getting the history it is then up to us with our different forms of examination to make a diagnosis. When it is made it is then our next move to get up a line of treatment.

Now it is right here that my subject comes in. Do not understand me to lessen the use of the *materia medica*, nor to belittle its place in the category of medical science. Not for a minute. My idea is that you cannot know too much about the subject, rather you can know too little of the subject. My whole aim in this humble paper is to point out the uses and especially the abuses. Know more about the subject and it broadens your opinion and you see less use for such a number. It seems to be the ambition of some physicians to get out some new uses or even new prescriptions. That is all right. It takes procedures of that kind to advance that branch of medical science. That does not alter the question of the case.

The practice of medical science is one of the oldest, and yet it takes a long while to eliminate the superstitions of the middle ages. But of recent years great advances have been made in medical science and especially in surgery. Other branches of medical science are being neglected in the craze for surgery. But right here let me tell you that we cannot all be surgeons. Now it rests with a majority of doctors to do for the practice of medicine what the surgeon has done for surgery.

Did you ever stop to think that two or three drugs as specifics are all that we can put down in our category

of medicine? Nearly all diseases are treated symptomatically. Now you can see at once our wide range in the use of drugs or the application of one or more different drugs used for different diseases or conditions giving the same symptoms. For safety to patient use the minimum amount of strong or poisonous drugs. We cannot quit giving medicine even if our patient does not need it, but you have at your disposal mild or non-poisonous drugs or even red water or placebos. If I am trying to be so zealous in protecting my patient or trying to be so honest, why should I use placebos at all? Giving placebos is a deception of the patient. Well yes, it is often so to a certain extent, but to hold the patient it is necessary at times to use them; else the patient will go to some one who will give him medicine or, as the patient expresses it, "do something" for him.

Gentlemen, after practicing medicine for eleven years I am convinced that many an innocent baby or child or adult has had his days shortened by indiscriminate giving of medicine, especially strong or poisonous drugs dispensed by ignorant, careless and possibly by over-zealous doctors.

Doctors, you young or recently made doctors especially, listen. Study and make every effort to find the trouble before you prescribe. After the diagnosis is made the treatment is easy. If the patient needs a purgative you know what to give; if he has malaria you know what to give; if he has typhoid fever you know too much to give. If the patient needs a heart stimulant you know what to give. If he needs an opiate or hypodermic you know what to give, but in extremes of age look out for your opiates, for you will certainly knock him out. It is hard to take medicine at its best or when you are well, but to be sick and have to take nauseating or very bad tasting medicine is almost the limit. Make your doses taste as well as possible, make your capsules small and, if possible, your powders tasteless.

And now in concluding let me say: when you visit a patient be cheerful, be kindly to your patient. Examine him carefully and show a great deal of interest and attention. This your patient needs at times much more than all the medicine you can give.

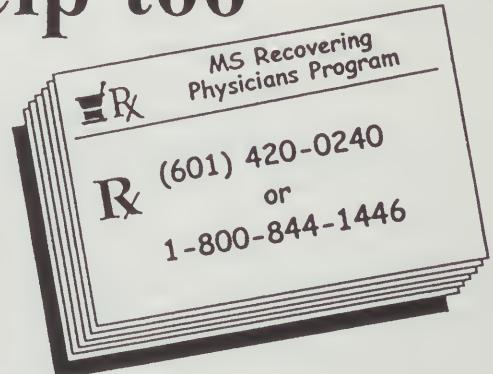
—W. W. Reynolds, M. D., Meridian
Transactions of the MSMA, 1909, 165-167

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AMA Foundation, Inc. Celebrates Golden Anniversary



Angie Bell, Chairman for Lee County Medical Alliance AMA Foundation Inc., receives the upcoming raffle tickets from Susan Rish. Who's going to be the lucky winner?

The AMA Foundation, Inc. is celebrating its golden anniversary this year. The AMA was founded in 1950 as a way of helping with operating money for medical schools and to support medical education. In 1952 the AMA Board of Trustees asked the Women's Auxiliary to the American Medical Association for help. What a wonderful thing to do to get the physicians' spouses involved! Today through the work of the AMA Alliance and thanks to their extraordinary fundraising efforts, the AMA Foundation continues to ensure quality medical education, research and service for the nation's people.

That is why it is so important for the Mississippi State Medical Association Alliance and its local county Alliances to be very diligent in raising money to support the AMA Foundation, Inc. This year for the 50th Anniversary I have designed a plan of fundraising projects that are simple, but yet effective. Whether you are a small Alliance, or one of the larger ones, there are fundraising projects for you.

This year we will be raffling two round-trip tickets to any Southwest destination. These tickets are selling for \$50 in honor of the 50th Anniversary. We are also privileged to be selling packets of Christmas Cards. These cards were donated by Ray Freeman, M.D. from Hale Center, Texas. Dr. Freeman is an artist and has donated cards to the Alliance in the past. These lovely cards will sell 25 cards for \$20.

This year's plan still contains some of the old faithful fundraisers such as the Christmas Sharing Card and Sally Foster Gift Wrap Sales. Ann Hopper, President of the MSMAA, has agreed to donate the proceeds of her book, entitled "Get a Life this year as well," when it is sold in a conjunction with a medical association. She donated over 12 thousand dollars to the AMA Foundation Inc. last year. As a climax to the year, we will again host the 2nd Annual Favorite Artists Show and Silent Auction at the State Convention in May 2001. Start thinking of whom you wish to invite to this exciting event. Last year's show was truly unbelievable and I am hoping that this year's show will be even better.

It is my personal goal to raise more money for the AMA Foundation, Inc. this year. We will have to work very hard, to do this. Last year's total donation from Mississippi was \$37,734.14. I felt very privileged to be among the Mississippi delegates as our state won special recognition at the National Convention in Chicago. So, everyone do your best and keep up the good work. Thank you for all you have done so far to make this Golden Year a success.

— Susan Rish, MSMA Alliance Third Vice President, AMA Foundation, Inc. Chairman

New Members

Anim-Addo, Edward K., Vicksburg, Born Ghana, August 12, 1963; MD, School of Medical Sciences, Ghana, 1991; Internal Medicine residency, Howard University, Washington, DC, 1994-97; elected by West MS Medical Society.

Cadle, Kimberly L., Natchez, Born Hattiesburg, February 14, 1970; MD, University of Arkansas, Little Rock, AR; Pediatric residency, Arkansas Children's Hospital, 1997-00; elected by Homochitto Medical Society.

Balthrop, Erica R., Clarksdale, Born Chicago, IL, December 9, 1964; MD, Chicago Medical School, Chicago, IL, 1996; OB/GYN residency, Cook County Hospital, Chicago, IL 1996-00; elected by Clarksdale Medical Society.

Chmelicek, Thomas V., Hattiesburg, Born Montreal Canada, May 17, 1969; MD University of Alberta, Edmonton, Alberta, 1999; Family Practice residency, Dalhousie University, Halifax, Nova Scotia, 1997-99; elected by South MS Medical Society.

Dey, Tayant, Tupelo, Born New Delhi, India, December 12, 1969; MBBS, India Institute of Medical Sciences, 1992; Internal medicine residency, Syracuse, NY, 1996-98; Endocrinology fellowship, Ochsner, New Orleans, LA, 1998-00; Elected by Northeast Medical Society.

Draper, Thomas S., Iuka, Born, Memphis, TN, August 29, 1966;

MD St. George's University School of Medicine, 1997; Family Practice residency, United Hospital Center, Clarksdale, WV, 1997-00; elected by Northeast Medical Society.

Flattman, Geoffrey, Natchez, Born, New Orleans, LA, May 6, 1969; MD, Louisiana State University School of Medicine, New Orleans, LA, 1995; General Surgery residency, Louisiana State University Medical Center, LA, 1995-00; elected by Homochitto Medical Society.

Gnam, Edward C., III, Jackson, Born, Denver, CO, May 1, 1969; MD, University of Texas Medical Branch, Galveston, TX, 1996; OB-GYN residency, University of Mississippi Medical Center, Jackson, MS, 1996-00; elected by Central Medical Society.

Grant, Vincent L., Clarksdale, Born Alabama, August 6, 1956; MD, University of Alabama School of Medicine, Birmingham, AL, 1985; General vascular surgery residency, Marshall University School of Medicine, Huntington, VA, 1992-97; elected by Clarksdale Medical Society.

Gutierrez, Yolanda, Pascagoula, Born, Nicaragua; MD, National Autonoma, University of Nicaragua, 1980; One year pediatric internship at Rafaela Padilla Hospital, 1980-81; pediatric residency; United Medical Center, New Orleans, LA, 1986-88; University of Alabama Medical Center, 1989-91; elected by Singing River Medical Society.

Hoang, Hoat M., Amory, Born Vietnam, December 29, 1968; MD Louisiana State University School of Medicine, New Orleans, LA, 1995; General Surgery residency, Louisiana State University, 1995-00; elected by Northeast Medical Society.

Pande, Narayan V., Gulfport, Born, India, April 4, 1934; MD, Osmania Medical College, Institute of Medical Science, Hyderabad, India, 1958; rotating residency internal medicine, Osmania University, Hyderabad, 1958-65 and Methodist Hospital, Brooklyn, New York, 1972-74; Gastroenterology fellowship, 1974-76; elected by Coast Co Medical Society.

Peavey, Michael T., Brookhaven, Born, Brookhaven, MS, August 6, 1968; MD, University of MS School of Medicine, Jackson, MS, 1994; one year pediatric internship, University of MS Medical Center, Jackson MS, 1994-95; surgery residency, University of MS Medical Center, 1995-00; elected by South Central Medical Society.

Peery, Michael L., Tupelo, Born, Columbia TN, April 4, 1956; MD, St. Louis University School of Medicine, 1994; surgery residency, University of Tennessee, Memphis TN, 1994-96; otolaryngology residency, University of Tennessee, Memphis TN, 1996-00; elected by Northeast Medical Society.

Russ, Jennifer, Natchez, Born, Alexandria LA, January 15, 1970; MD Louisiana State University School of Medicine, New Orleans

Eligible employed and resident physicians

LA, 1997; pediatrics residency, Arkansas Children's Hospital, Little Rock AR, 1997-00; elected by Homochitto Medical Society.

Saul, Chad, Laurel, Born Meridian MS, September 9, 1969; MD, Tulane University School of Medicine, New Orleans LA, 1995; surgery residency, Bowman Gray/North Carolina Baptist Hospital and Indiana University/Methodist Hospital of Indianapolis; elected by South MS Medical Society.

Stewart, John A., Yazoo City, Born, Dallas TX, October 6, 1962; MD, East Tennessee State University College of Medicine, Johnson City TN, 1991; pathology residency, Medical College of Virginia, 1991-96; family medicine residency, University of Mississippi Medical Center, Jackson MS, 1997-00; elected by Central Medical Society.

Tanaka, Linda, Jackson, Born Sacramento CA, September 13, 1968; MD Tulane University School of Medicine, New Orleans LA, 1995; pediatrics residency, Tulane University School of Medicine, New Orleans LA, 1995-98; Allergy & Immunology fellowship, Tulane University School of Medicine, New Orleans LA, 1998-00; elected by Central Medical Society.

Teran, Juan C., Ocean Springs, Born, Tampico Mexico, October 9, 1956; MD, Universidad Autonoma del Estado de Mexico, Toluca Mexico, 1985; internal medicine residency, Metro Health Medical Center, Case Western University, Cleveland OH, 1989-91; gastroenterology residency, Metro Health Medical Center, Case West-

ern University, Cleveland OH, 1991-96; elected by Singing River Medical Society.

Wade-Hemme, Joyce D., Jackson, Born, Starkville MS, January 8, 1968, MD, University of Mississippi School of Medicine, Jackson MS, 1994; internal medicine residency, University of MS Medical Center, Jackson MS; elected by Central MS Medical Society.

Woodard, Steven D., Louisville, Born September 19, 1968; MD, University of Mississippi School of Medicine, Jackson, MS, 1995; Family Practice residency, University of Alabama, 1996-98; elected by East MS Medical Society.

Yarber, Robert, Tupelo, Born, Tupelo MS, November 18, 1966; MD, University of Tennessee, Memphis TN, 1994; general surgery residency, Memphis TN, 1994-96; otolaryngology residency, Memphis TN, 1996-00; elected by Northeast Medical Society.

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Personals

Walter C. Gough, M.D. and W. Briggs Hopson, Jr., M.D. have been appointed to the Mississippi State Board of Health by Governor Ronnie Musgrove. Gough, who runs the Gough's Family & Pediatric Clinic in Drew, will represent the 2nd Congressional District for a six-year term ending July 1, 2006. Hopson, who was also appointed to represent the 2nd Congressional District, is a general and peripheral vascular surgeon with The Street Clinic. He is also president of the clinic, medical director and member of the board of directors of the River Region Medical Corp., chief of surgery and chief of staff for ParkView Regional Medical Center, medical control director for emergency medical services for Mississippi and chairman of the state paramedic committee. He also played a large role in establishing the state's trauma-care system. Other MSMA members appointed by the governor were **Barbara Smith, M.D.** of Southaven, a staff member of the DeSoto Family Medical Center, and **Steven W. Stogner, M.D.** of Hattiesburg, on the staff of the Internal and Pulmonary Medicine Clinic.

Pami Taylor, M.D. has joined **Drs. J.D. Loden, Mary Pace, Ricky Parker, and Paul White** for the Practice of Internal Medicine in Tupelo.

Austin P. Boggan, M.D. of Decatur has been selected by the Mississippi Chapter of the American Academy of Family Physicians to receive the John B. Howell Award Memorial Award for the Family Practice Physician of the Year 2000. He received the award at a banquet held on the last evening of the Mississippi Academy of Family Physicians Annual Scientific Assembly. The John B. Howell Memorial Award is given in appreciation and recognition of outstanding leadership and service by the Mississippi Chapter of the American Academy of Family Physicians.

Larry T. Holifield, M.D. has joined MEA Primary Care Plus in Laurel. A Laurel native, Dr. Holifield is a graduate of the University of Southern Mississippi and the West Virginia School of Osteopathic Medicine. He completed his family medicine residency at the University of Mississippi Medical Center. He is a board certified family medicine physician.

Robert Hotchkiss, M.D. is the new District Health Officer for West Central Public Health District V, headquartered in Jackson. The former director of Community Health Services for the Department will apply his extensive public health experience to leading the ten-county district. **Don Grillo, M.D.** retired in June 2000 after having served as district health officer for the Jackson Metro Area since 1989. Dr. Hotchkiss' new assignment covers Claiborne, Copiah, Hinds, Issaquena, Madison, Rankin, Sharkey, Simpson, Warren and Yazoo counties. His public health career includes work experience with the Arkansas State Department of Health, the Kansas City Missouri State Department of Health, and the Mississippi State Department of Health in program areas of community health, maternal and child health, and preventive health. He previously served as health officer for Coastal Plains Public Health District, headquartered in Gulfport.

Max L. Pharr, M.D. announces his retirement from the practice of Canton Family Health Clinic.

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First Three Barksdale Medical Scholarships Awarded



Dr. Wallace Conerly, left, UMC vice chancellor, greets Barksdale Scholars, from left, Angelica Dache Haynes, Eboni Mikelle Smith and Marcus Louis Britton at the white coat ceremony for freshman medical students.

The first three African-American students selected to receive scholarships made possible by the Barksdale Family Account in the University of Mississippi Foundation have enrolled in medical school at the University of Mississippi Medical Center.

The three students, Marcus Louis Britton, who holds the Bryan Barksdale, M.D., Scholarship, Angelica Dache Haynes, who holds the Fred McDonnell, M.D., Scholarship, and Eboni Mikelle Smith, who holds the Don Mitchell, M.D., Scholarship * will receive "full ticket" scholarships worth approximately \$22,000 for each year of medical school. The scholarships were made possible by a \$2 million gift from James and Sally Barksdale to encourage highly qualified African-American

medical students to stay in Mississippi for their medical training.

"In the last 18 years, the School of Medicine has lost 80 black students to medical schools in other states * primarily because other medical schools offered better financial aid packages," said Dr. Wallace Conerly, Medical Center vice chancellor for health affairs. "Once they leave the state, the chances of their returning home to practice are slim." Mississippi needs African-American physicians, he said, to help boost the health status of African-Americans in Mississippi. The three scholarships cover the \$6,900 tuition and other expenses.

The Barksdales named the scholarships to honor the physicians in their family, Dr. Bryan Barksdale and

Dr. Don Mitchell of Jackson and Dr. Fred McDonnell of Hazlehurst.

Britton is a graduate of St. Andrew's Episcopal School in Jackson and majored in biology at Samford University in Birmingham, Alabama. At Samford, he was on the Dean's List and received several scholarships for academic merit. A Samford Ambassador, he was tapped for membership in Beta Beta Beta Biology Honor Society and was a member of the Student National Medical Association.

Britton has volunteered at the Brookwood Medical Center and worked at the Mississippi Baptist Medical Center and Jackson State University during summers.

Haynes graduated from Hazlehurst High School in 1996 and received the BS at Tulane University this year. At Tulane, she received the Dave, Hazel and Donald Marcus Scholarship for academic excellence and was recognized as a Newcomb Asset. She served on the NO/AIDS task force, was a Newcomb senator, and peer health advocate.

During summers, she was a program coordinator at Pinecrest Retirement Home, a pre and post test HIV

test counselor at the Copiah County Health Department and a research assistant at the Medical College of Ohio. She has volunteered in the Medical Center's Blair E. Batson Hospital for Children.

Smith is a graduate of Callaway High School in Jackson and Xavier University of Louisiana in New Orleans. At Xavier, she was named to the Dean's List and was the recipient of a Howard Hughes Biomedical Scholarship, a Xavier University Academic Scholarship and All-American Collegiate Scholarship. She was tapped for membership in Beta Beta Beta Biology Honor Society. She did hospital volunteer work, volunteered in a mentoring and tutoring program at Xavier and participated in the College Fund Walk-A-Thon and Community Plunge.

Barksdale is a former Netscape CEO and a native Mississippian. He and his wife Sally, both graduates of the University of Mississippi, also provided funds to establish the Barksdale Honors College at the University and recently established the statewide Barksdale Reading Institute to promote literacy.

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MANUSCRIPTS should be of an appropriate length due to the policy of the Journal to feature concise but complete articles. (Some subjects may necessitate exception to this policy and will be reviewed and published at the Editor's discretion.) The language and vocabulary of the manuscript should be understandable and not beyond the comprehension of the general readership of the Journal. The Journal attempts to avoid the use of medical jargon and abbreviations. All abbreviations, especially of laboratory and diagnostic procedures, must be identified in the text. Manuscripts must be typed, double-spaced with adequate margins. (This applies to all manuscript elements including text, references, legends, footnotes, etc.) **The original and one duplicate should be submitted. The Journal also requires manuscripts in the form stated above on IBM-compatible floppy diskette.** Please identify the word processing program used and the file name. Pages should be numbered. An accompanying cover letter should designate one author as correspondent and include his/her address and telephone number. Manuscripts are received with the explicit understanding that they have not been previously published and are not under consideration by any other publication. Manuscripts are subject to editorial revisions as deemed necessary by the editors and to such modifications as to bring them into conformity with Journal style. The authors clearly bear the full responsibility for all statements made and the veracity of the work reported therein.

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TITLE PAGE should carry [1] the title of the manuscript, which should be concise but informative; [2] full name of each author, with highest academic degree(s), listed in descending order of magnitude of contribution (only the names of those who have contributed materially to the preparation of the manuscript should be included); [3] a one- to two-sentence biographical description for each author which should include specialty, practice location, academic appointments, primary hospital affiliation, or other credits; [4] name and address of author to whom requests for reprints should be addressed, or a statement that reprints will not be available.

ABSTRACT, if included, should be on the second page and consist of no more than 150 words. It is designed to acquaint the potential reader with the essence of the text and should be factual and informative rather than descriptive. The abstract should be intelligible when divorced from the article, devoid of undefined abbreviations. The abstract should contain: [1] a brief statement of the manuscript's purpose; [2] the approach used; [3] the material studied; [4] the results obtained. Emphasize new and important aspects of the study or observations. The abstract may be graphically boxed and printed as part of the published manuscript.

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SUBHEADS are strongly encouraged. They should provide guidance for the reader and serve to break the typographic monotony of the text. The format is flexible but subheads ordinarily include: Methods and Materials, Case Reports, Symptoms, Examination, Treatment and Technique, Results, Discussion, and Summary.

REFERENCES must be double spaced on a separate sheet of paper and limited to a reasonable number. They will be critically examined at the time of review and must be kept to a minimum. All references must be cited in the text and the list should be arranged in order of citation, not alphabetically. Personal Communications and unpublished data should not be included in references, but should be incorporated in the text. The following form should be followed:

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[1] **Author(s).** Use the surname followed by initial without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used, followed by "et al." [2] **Title of article.** Capitalize only the first letter of the first word. [3] **Name of Journal** followed by no punctuation, underscored or in italics, and abbreviated according to List of Journals Indexed in Index Medicus. [4] **Year of publication;** [5] **Volume number:** Do not include issue number or month except in the case of a supplement or when pagination is not consecutive throughout the volume. [6] **Inclusive page numbers.** Do not omit digits.

Example: Bora LI, Dannem FJ, Stanford W, et al. A guideline for blood use during surgery. *Am J Clin Pathol.* 1979;71:680-692.

Books

[1] **Author(s).** Use the surname followed by initials without punctuation. The names of all authors should be given unless there are more than three, in which case the names of the first three authors are used followed by "et al." [2] **Title,** Capitalize the first and last word and each word that is not an article, preposition, or conjunction, of less than four letters. [3]

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The association's newsletter is published monthly and contains information on current medical events and association activities that are important to the medical profession.

The MSMA Legislative 601-853-6733
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Published weekly during each annual session of the Mississippi Legislature, this informative newsletter provides association members with the latest news on legislative and political events. It also keeps members abreast of health legislation that is under consideration and the association's position on hundreds of health-related bills.

Legal Information 601-853-6733
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Although the association does not provide individual legal representation for members, it will provide general legal information and opinions on Mississippi and federal laws, regulations and court decisions.

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MSMA members receive a Membership Director which is published annually and includes the practice address, telephone number, e-mail address and specialty of each MSMA member by county.

Legislative Forum 601-853-6733
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The association's Annual Session includes meetings of the policy-making House of Delegates, plus a variety of other specialty, educational and business meetings and social events. It also includes a day

long medical issues forum where CME credit is available for attendees. Dates for upcoming meetings on the Mississippi Gulf Coast are as follows: May 4-6, 2001; May 3-5, 2002; May 16-18, 2003 and June 4-6, 2004.

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Female members of the association meet periodically to discuss their mutual concerns and work on a number of initiatives that target women. Members of the caucus also hold an annual breakfast meeting with female members of the Mississippi Legislature.

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Each recognized component society of the association is represented in the House of Delegates, which is the official policy-making body for MSMA. The House of Delegates, which meets each year during the association's Annual Session, affords physicians the opportunity to participate with their colleagues in determining how medicine approaches various health care issues in Mississippi.

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The association has a number of standing committees that deal with specific areas affecting health and medical care, from legislation to education. Council and committee seats are filled through either election by the House of Delegates or appointment by the MSMA President or Board of Trustees. Interested members are encouraged to submit their names for nomination or appointment.

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The association has a full-time staff that works on legislative and regulatory matters affecting physicians and their patients. These representational efforts are one of the most valuable services an association can provide, but to be effective they require the members' support and involvement. You can help by getting to know your state and local elected officials and contacting them when requested by MSMA.

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Mississippi Baptist Medical Center
1225 N. State St.
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Jackson, MS 39215

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Cover photo: This fall scenic off the Natchez Trace Parkway near the Ross Barnett Reservoir was taken by R. C., "Corky" Sneed, M.D., Pediatrician, Physical Medicine and Rehabilitation Specialist, Medical Director of Children's Rehabilitation Center, University Medical Center. Roughly following old Native American trails, the trace was made possible by treaties in 1801 between the United States and the Chickasaw and Choctaw tribes that allowed the U.S. Army to improve the route as a post road. Granite markers now identify the site of the old highway. Initial funding for the Natchez Trace Parkway was allocated in 1934; it was officially established in 1938. The parkway, extending 501 miles, is administered by the National Park Service to commemorate this historic route.

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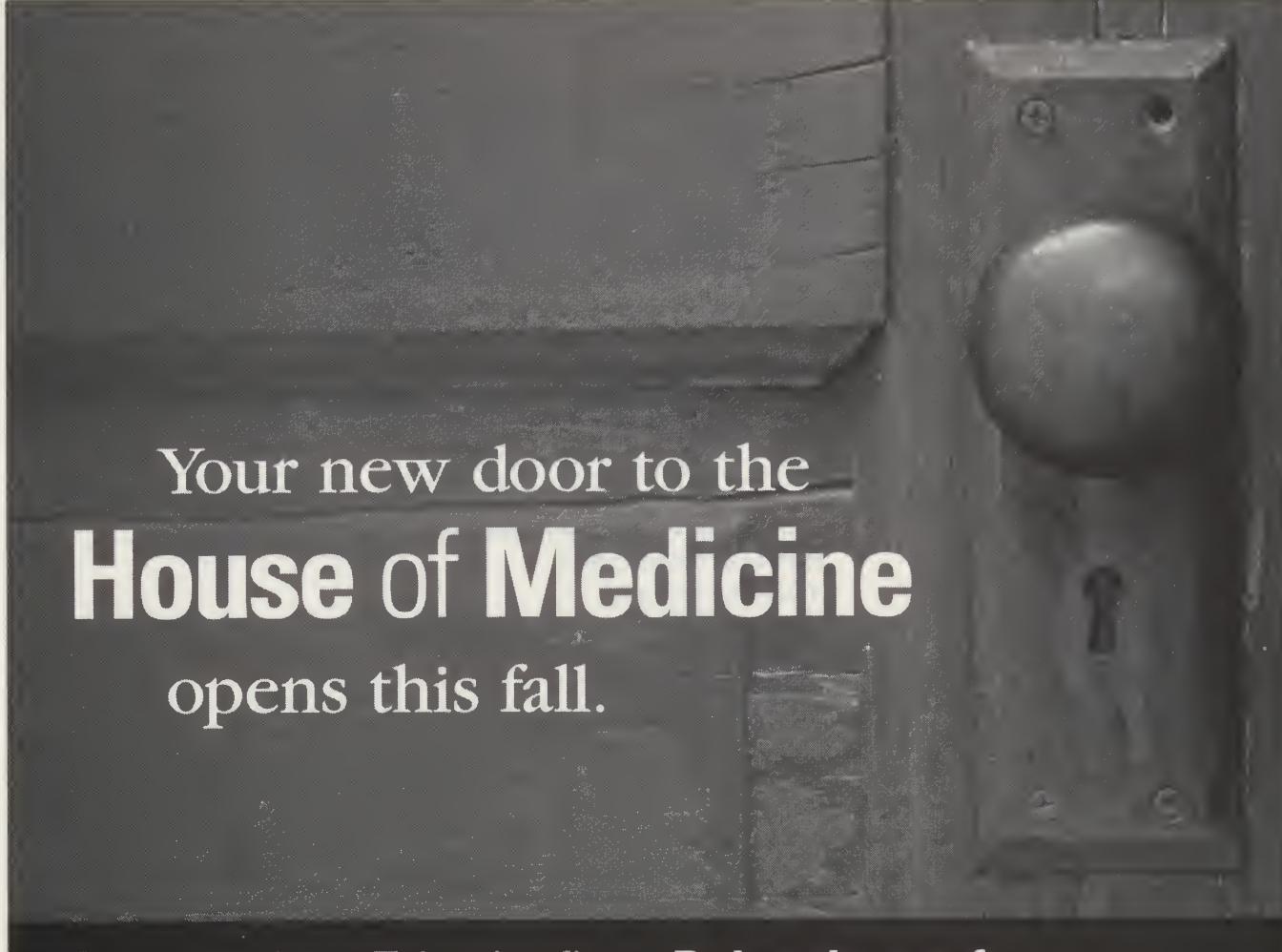
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Epidemiology Report Overweight and Obesity in Mississippi: A Growing Problem

Alan D. Penman, MBChB, MSc, MPH

Overweight and obesity are the most common and costly nutritional problems in the U.S. today and have now reached epidemic proportions. This report describes the prevalence, trends, and high-risk groups in Mississippi.

Definitions of Overweight and Obesity

It is usual now to differentiate between overweight and obesity, because of the markedly higher risks of disease and premature mortality associated with the latter. Body mass index (BMI) is currently the most commonly used measure of overweight and obesity in adults [formula: weight (in kilograms) divided by height (in meters) squared, or weight (in pounds) multiplied by 705 then divided by height (in inches) squared]. The older definitions of adult overweight and obesity are based on data from the second National Health and Nutrition Examination Survey of 1976-80: overweight is defined as $BMI \geq 27.8$ (the 85th percentile for 20-29 year old men) or ≥ 27.3 (the 85th percentile for 20-29 year old women); obesity is defined as $BMI \geq 30.0$ (close to the 95th percentile for 20-29 year olds of both sexes*).¹ A BMI of 27.8 in men and 27.3 in women corresponds to approximately 120% of desirable weight for height using the 1983 Metropolitan Height and Weight tables; a BMI of 30 corresponds to approximately 140% of desirable weight for height. Using this definition, overweight and obesity are not mutually exclusive, since obese persons are also overweight.

In 1998, on the basis of new data associating overweight and obesity with mortality, the National

Heart, Lung, and Blood Institute changed the definition of overweight to include all persons with a $BMI \geq 25.0$ but < 30.0 .² The definition of obesity remained unchanged at $BMI \geq 30.0$. Mortality is 10-25% higher for persons with a BMI between 25 and 30, and 50-100% higher for persons with a BMI of 30 or higher.²

This new definition is in agreement with those used by the World Health Organization and the International Obesity Task Force. Strictly speaking, overweight and obesity are now mutually exclusive. However, to be consistent with the old definition I shall use the new definition *inclusively* in this report: overweight refers to $BMI \geq 25.0$ and obesity to $BMI \geq 30.0$.

In children and adolescents, slightly different BMI criteria are used, based on the results of the second (1963-65) and third (1966-70) National Health Examination Surveys and the first (1971-74), second (1976-80), and third (1988-94) National Health and Nutrition Examination Surveys. An individual is considered *at risk of becoming overweight* if his or her BMI is $\geq 85^{\text{th}}$ percentile but $< 95^{\text{th}}$ percentile for BMI by age and sex, and *overweight* if his or her BMI is $\geq 95^{\text{th}}$ percentile for BMI by age and sex.^{3,4} A more conservative definition of overweight is used to allow for growth spurts and other physiological changes, and usually no distinction is made between *overweight* and *obesity*. It should be noted that there is still no internationally agreed definition of overweight and obesity in children and adolescents.

* to be exact, the 95th percentile is 31.1 for men and 32.3 for women

Sources of Data on Overweight and Obesity in Mississippi

Behavioral Risk Factor Surveillance System (BRFSS)

The BRFSS is a random telephone survey of adults on health and health care behaviors that has been conducted by Mississippi since 1990 on a continuous basis throughout each year. Respondents are asked to give their height and weight, as well as answer a number of questions on weight and weight control. 1999 is the latest year for which state-specific data on weight and weight control are available; 1998 is latest year for which national data are available.

Youth Risk Behavior Survey (YRBS)

The YRBS is a self-administered questionnaire survey of public high school students (grades 9-12) in Mississippi. It was conducted in 1990 and thereafter in alternate years beginning in 1993. In 1990 and the period 1993-97, data on height and weight were not collected in the YRBS, so BMIs could not be calculated. Answers to weight-related questions were, therefore, self-reported and the data should be interpreted with caution. In the 1999 YRBS, self-reported height and weight data were collected for the first time, allowing calculation of BMIs. 1999 is the latest year for which state-specific data on weight and height are available; national data are also available for 1999.

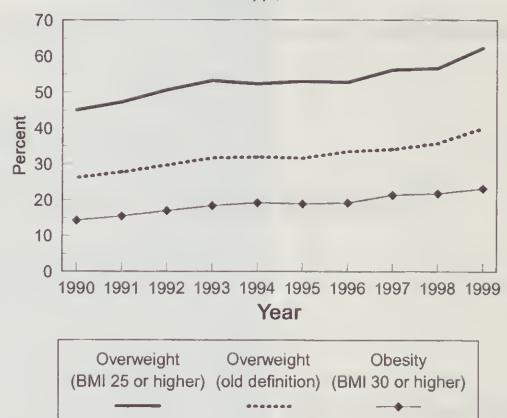
Overweight in Adults: Prevalence and Time Trends

Using the old definition, in 1999, 40% of adult Mississippians were overweight, including 23% who were obese. There has been a fourteen percentage point increase in the prevalence of overweight since 1990 (when state-specific population estimates first became available), which represents a relative change of about 4% per year on average (Figure 1).

The prevalence of overweight (using the old definition) has increased in all age/sex/race groups, but the greatest average increase over the period 1990-99 has been in the young adult age groups: in the 18-24 year old age group for African-American males and White females and in the 25-34 year old age group for White males and African-American females (data not shown).

Using the new definition, in 1999, 62% of Mississippians were overweight, including 23% who were obese. This figure has increased by seventeen percentage points since 1990, a relative change of nearly 3% per year on average (Figure 1).

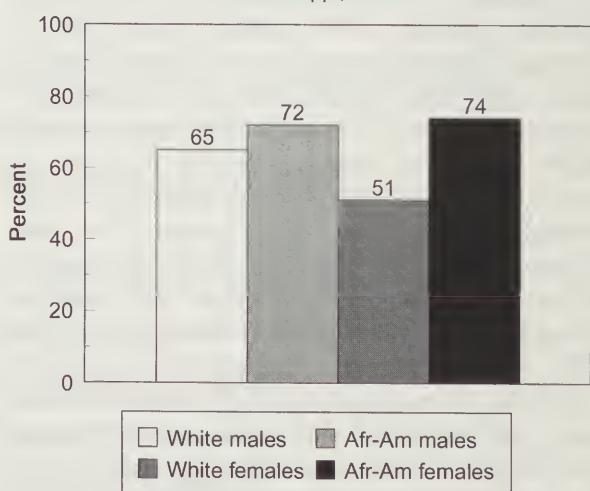
Figure 1. Prevalence of adult overweight and obesity
Mississippi, 1990-99



High-Risk Groups for Adult Overweight

Among adults, males have slightly higher rates of overweight than females, and African-Americans have markedly higher rates than whites. However, all groups have high rates. Nearly three-quarters of African-American men and women are overweight (Figure 2). In terms of actual numbers, it is estimated that there are 1,152,775 overweight adults in the state; 401,638 (35%) are White males, 191,419 (17%) are African-American males, 327,913 (28%) are White females, and 231,805 (20%) are African-American females.

Figure 2. Prevalence of adult overweight (BMI 25 or higher)
Mississippi, 1999



The prevalence of overweight is greatest in the 55-64 year old age group in women, but in men it peaks at younger ages: 25-34 in White males and 35-44 in African-American males. However, the prevalence is high at most ages in all population groups. Whites have a lower prevalence in the younger age groups, whereas in African-Americans the prevalence is already high in the 18-24 year olds (Table 1).

Table 1. Prevalence (%) of adult overweight (BMI ≥ 25.0), Mississippi, 1999

Age group	White males	African-American males	White females	African-American females
18-24	40	72	44	62
25-34	74	63	41	72
35-44	70	82	50	67
45-54	72	69	58	86
55-64	64	77	59	90
65+	62	75	52	79

Source: Behavioral Risk Factor Surveillance System (BRFSS)

All percentages are rounded to the nearest whole number

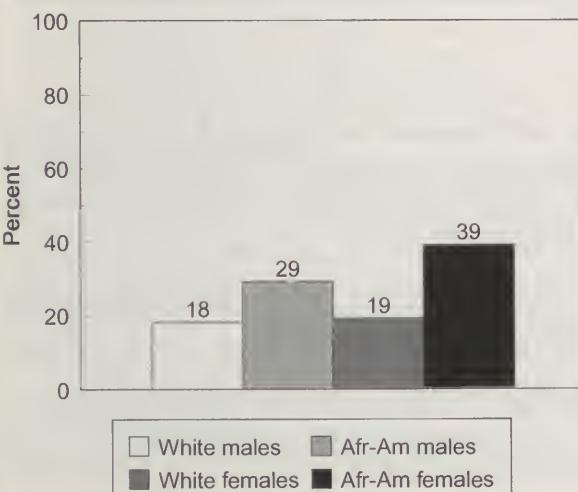
Obesity in Adults: Prevalence and Time Trends

In 1999, 23% of adult Mississippians were obese. There has been a nine percentage point increase in the prevalence of obesity since 1990, a relative change of about 5% per year on average (Figure 1).

High-Risk Groups for Adult Obesity

Among adults, females have slightly higher rates of obesity than males, and African-Americans have markedly higher rates than whites. One third of African-American men and women are obese, almost double the rate in whites (Figure 3). In terms of actual numbers, it is estimated that there are 433,642 obese adults in the state; 111,755 (26%) are White males, 77,473 (18%) are African-American males, 122,934 (28%) are White females, and 121,480 (28%) are African-American females.

Figure 3. Prevalence of adult obesity (BMI 30 or higher)
Mississippi, 1999



In all population groups the prevalence of obesity tends to peak in middle age. It is greatest in the 45-54 year old age group in African-Americans, but in whites it peaks at 35-44 in men and 55-64 in women. The highest prevalence (56%) is in African-American females in the 45-54 year old age group (Table 2).

Self-Reported Weight Control Behaviors in Adults

In 1998 (the latest year for which these data are available):

- 36% of Mississippi adults reported that they were trying to lose weight
- 62% of Mississippi adults reported that they were trying to maintain their current weight (i.e., trying to keep from gaining weight)
- 13% of Mississippi adults reported that they had been advised to lose weight by a health professional in the past 12 months
- 71% of Mississippi adults were eating fewer calories and/or less fat to lose weight or keep from gaining weight
- 52% of Mississippi adults were using physical activity or exercise to lose weight or keep from gaining weight

National Comparisons

In 1998 (the latest year for which comparison data from other states are available), West Virginia (37.8%) and Mississippi (37.5%) had the highest prevalence rates of overweight (using the *older* definition[†]) in the nation. Arizona had the lowest state rate (22.5%), a difference of 15 percentage points (Table 3). The me-

Table 2. Prevalence (%) of adult obesity (BMI ≥ 30.0), Mississippi, 1999

Age group	White males	African-American males	White females	African-American females
18-24	15	20	17	21
25-34	17	27	13	40
35-44	23	38	21	38
45-54	21	41	20	56
55-64	14	21	27	44
65+	16	25	17	40

Source: Behavioral Risk Factor Surveillance System (BRFSS)

All percentages are rounded to the nearest whole number

dian prevalence for the U.S. was 32.4%. The wide range of prevalence rates among states represents the influence of physical, social, and cultural factors on the

Using BMI calculations rather than self-reports, the prevalence of adolescent overweight shows a similar pattern. In 1999, 30% of public high school students

Table 3. Prevalence (%) of adult overweight (BMI ≥ 27.8 (men) or ≥ 27.3 (women)): top five and bottom five ranked states, 1998

Five states with the highest prevalence	Prevalence of overweight (%)	Five states with the lowest prevalence	Prevalence of overweight (%)
West Virginia	37.8	Connecticut/Vermont	27.4
Mississippi	37.5	Colorado	27.2
Alaska	33.9	Nevada	27.0
Louisiana	36.2	Massachusetts	26.9
Alabama/Kentucky	36.1	Arizona	22.5

Source: Behavioral Risk Factor Surveillance System (BRFSS)

U.S. median: 32.4%

population distribution of body weight.

Overweight in Adolescents: Prevalence and Time Trends

In 1999, almost one third (30%) of public high school students in Mississippi reported that they were slightly or very overweight, and 41% of students reported that they were trying to lose weight. The prevalence of self-reported overweight showed a downward trend between 1993 and 1997, but there was a five percentage point increase in 1999 (Table 4).

were $\geq 85^{\text{th}}$ percentile for BMI by age and sex: 13% of students were overweight ($\geq 95^{\text{th}}$ percentile) and 17% were at risk of becoming overweight ($\geq 85^{\text{th}}$ percentile but $< 95^{\text{th}}$ percentile).

[†] comparison data for other states using the new definition are not yet available

High-Risk Groups for Adolescent Overweight

The prevalence of self-reported overweight varied by sex and race: 24% of boys vs. 35% of girls; 33% of

Table 4. Trends in the prevalence (%) of self-reported overweight in public high school students, Mississippi, 1993-97

Year	1993	1994	1995	1996	1997	1998	1999
Prevalence	32	n/a	29	n/a	25	n/a	30

Source: YRBS n/a=not available

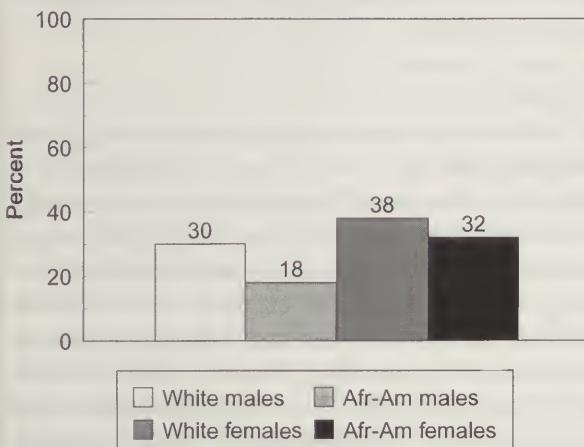
All percentages are rounded to the nearest whole number

white students vs. 26% of African American students. The prevalence was highest in White females (38%) and lowest in African-American males (18%) (Figure 4), and 11th graders (32%) had a higher rate than 9th, 10th, and 12th graders, though the differences between grades were not large.

The percentage of students trying to lose weight also varied by sex and race: 25% of boys vs. 56% of girls; 37% of white students vs. 44% of African American students. This prevalence was also highest in White females (63%), followed by African-American females (49%), White males (27%), and African-American males (23%), and higher in 10th grade (42%) than other grades, though again the inter-grade differences were small.

Figure 4. Prevalence of self-reported overweight in public high school students

Mississippi, 1999



Summary and Conclusions

The difficulties, complexities, hazards, and failures of treatment for overweight and obesity argue strongly for an approach that prevents excessive weight gain. The prevalence and trends data support a preventive approach beginning in childhood and adolescence but also targeting college-age students and young adults:

- the prevalence of overweight is already high (30%) in adolescents
- prevalence rates increase markedly in the col-

lege years (compare the rates in the 18-24 and 25-34 year old age groups with the rates in the older age groups)

- the greatest average increase in prevalence rates over the period 1990-99 has been in the 18-24 and 25-34 year old age groups (data not shown)

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Other references are available on request. A useful Internet site for statistics related to overweight and obesity in the U.S. is <<http://www.niddk.nih.gov/health/nutrit/pubs/statobes.htm>>. A color chart for determining BMI can be obtained from the Mississippi Chronic Illness Coalition ((601) 576-7781). Alternatively, go to the BMI calculator at: <<http://www.nhlbisupport.com/bmi>>.

Dr. Penman is a physician and epidemiologist with the Mississippi State Department of Health and a Clinical Instructor in Preventive Medicine at the University of Mississippi School of Medicine, positions which he has held since 1996.

Address correspondence: Alan D. Penman
 Office of Community Health Services
 Mississippi State Department of Health
 570 East Woodrow Wilson
 Jackson, MS 39216
 Phone: 601-576-7842, Fax: 601-576-7497
 e-mail: apenman@msdh.state.ms.us

Management of Pregnancy Related Carpal Tunnel Syndrome

Michael C. Graeber, M.D.
Aubrey B. Lucas, M.D.

Carpal Tunnel Syndrome is the most common entrapment neuropathy. Though there are many common diagnostic associations, it is well known that carpal tunnel syndrome frequently occurs during pregnancy. Symptoms typically increase in frequency and severity in the third trimester and usually resolve rapidly post-partum.

Over twenty percent of pregnant women may have symptoms of carpal tunnel, and symptoms are bilateral in about one half of these women. Though the hand, wrist, and forearm pain may be severe, interfering with sleep, symptoms can usually be controlled during pregnancy with the use of nocturnal wrist splints; however, some patients can develop more significant median nerve compression at the wrist, which results in significant sensory and motor axon loss.

CASE # 1

CJ: A twenty-nine year old attorney, was seen during the fifth month of her pregnancy, with complaints of bilateral hand tingling and numbness which had begun approximately two months previously. Over the past few weeks, she had noted that both hands were "staying numb" and she complained of difficulty "using both hands". Her examination revealed a positive phalen's maneuver as well as overt tinels phenomenon at both wrists. She had hypesthesia to touch in median digits. Electrophysiologic studies (EMG/NCV) revealed markedly reduced-dispersed-delayed sensory responses, delayed transcarpal motor conduction to the abductor pollicis brevis muscles bilaterally, and EMG evidence of motor

axon loss with active denervation in the abductor pollicis brevis muscles bilaterally. These electrophysiologic findings were felt to reflect significant (moderate to advanced) median nerve compression at the wrists. She subsequently underwent bilateral carpal tunnel releases under local anesthesia and experienced significant improvement in her symptoms post-operatively.

CASE # 2

SW: A twenty-two year old, was seen approximately two months after delivery. She related that during the mid portion of her pregnancy, she developed severe wrist-hand pain and edema. She reported her pain and hand numbness was prominent at night and significantly interfered with her sleep. She was reassured, and her symptoms persisted during pregnancy. Her hand pain essentially resolved upon delivery, approximately three months after symptom onset. She was referred for neurophysiologic studies approximately two months post delivery because of persistent numbness in both her hands. Her distal arm, wrist, and hand pain had essentially resolved at the time of her EMG and Nerve Conduction Studies. Her electrophysiologic studies revealed markedly reduced-dispersed median digital sensory responses, indicative of sensory axon loss. She had overt transcarpal motor delays with evidence of motor axon loss in her abductor pollicis brevis muscles bilaterally. These neurophysiologic findings were felt to reflect "Moderate to Advanced" median neuropathy at both wrists.

DISCUSSION

Carpal Tunnel Syndrome is a compression neuropathy with various presentations and etiologies. The most common presentation of carpal tunnel syndrome is intermittent hand pain and tingling (paresthesias). Patients often times note "hand swelling" and symptoms are frequently quite bothersome at night. It is a common problem, even in the general population, with an estimated lifetime risk of approximately 10 percent. Over 20 percent of pregnant women may have symptoms of carpal tunnel syndrome, though for many, the symptoms are relatively mild and are self limiting, with resolution post delivery. On the other hand, a number of patients with gestational carpal tunnel syndrome, (as demonstrated by our two cases), will develop more significant nerve compression, complicated by sensory and motor axon loss. Significant median sensory nerve fiber loss (clinical numbness) can be quite troublesome to people who depend on good tactile sensation. In addition, motor nerve fiber loss can result in hand muscle dysfunction, weakness, and can further impair hand functioning. The goal of effective therapy would be to identify those persons at highest risk for significant nerve compression, and to intervene to prevent significant nerve damage from occurring. Though the correlation between symptoms of carpal tunnel syndrome and electrophysiologic studies (EMG/Nerve Conduction Studies) is certainly not 100%; Electrophysiologic testing is very accurate at detecting changes in nerve conduction as well as sensory and motor nerve fiber loss, which is the very complication we are trying to prevent with surgical decompression of an entrapped nerve. Therefore, given the high incidence of carpal tunnel syndrome symptoms during pregnancy, the fact that many of these patients are only mildly symptomatic, and the fact that the majority of symptoms will completely resolve post-partum, treatment can start conservatively. If symptoms are relatively mild, not associated with any median territory sensory changes (Digits 1-3), then reassurance, along with education about resolution upon delivery would be all that is needed. For patients with somewhat more troubling symptoms, wrist splints, especially if worn at night, can be very helpful. However, patients with severe pain and paresthesias, particularly if producing significant insomnia, and certainly those with any clinical sensory loss (hypoesthesia in digits 1-3) or motor weakness in the abductor pollicis brevis, should be considered for further evaluation and treatment. If electrophysiologic studies reveal significant median nerve compression in the carpal tunnel, particularly if associated with axon loss, then more definitive treat-

ment such as surgical decompression should be considered. This can be easily performed, even in the pregnant patient, under local anesthesia with minimal perioperative risks.

Though gestational carpal tunnel syndrome is a relatively common problem, usually self-limiting and resolves post-partum, there are certainly patients who are significantly affected because of prominent symptoms as well as those who will sustain significant nerve compression and perhaps irreversible nerve damage. The above described diagnostic and treatment approach provides an algorithm to manage pregnancy related carpal tunnel syndrome.

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Dr. Graeber is a neurologist with subspecialty certification in clinical neurophysiology. His practice is limited to electrodiagnostics. His office is located at St. Dominic Medical Offices; West Tower, Suite 560, 971 Lakeland Drive, Jackson, MS.

Dr. Lucas is an orthopaedic surgeon whose practice is limited to disorders of the hand and arm. His office is located at 1020 River Oaks Dr., Suite 450, Jackson, MS.

You can dress a pig up...

but it's still a pig.

For months, the Senate Republican leadership has dressed up an HMO Protection Act and is trying to pass it off as an acceptable "Patients' Bill of Rights."

But even a dressed up pig is still...a pig.

When the real Patients' Bill of Rights was debated in the Senate earlier this year, Senator Don Nickles introduced an amendment that was a silk purse for HMOs. And many Senate Republicans were led to believe that the Nickles Amendment actually lived up to its title.

It wasn't until after the fact that many Senators learned the truth — that the Nickles Amendment would harm, not help how patients could fight back against managed care abuses.

Under the guise of helping patients, the Nickles Amendment would have granted HMOs new legal protections and, in many cases, complete immunity from suits by injured patients.

The Nickles Amendment would also gut any external review process by allowing HMOs to impose narrow definitions of medical necessity.

The final decision on the real patients' bill of rights is only days away, the election only weeks away. Voters will be watching closely to see whether their Senator votes for a real patients' bill of rights... or a dressed up pig.



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Gratitude

**Candace E. Keller, M.D., M.P.H.
The President's Page**

As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live them.”

— John F. Kennedy

November is the month in which we celebrate the holiday known as “Thanksgiving”. It is a day we set aside to give thanks for our blessings both large and small. Perhaps too often, we exert more time and energy metabolizing our overindulgence at the dinner table than perhaps we should, but hopefully we also spend a few moments in reflection.

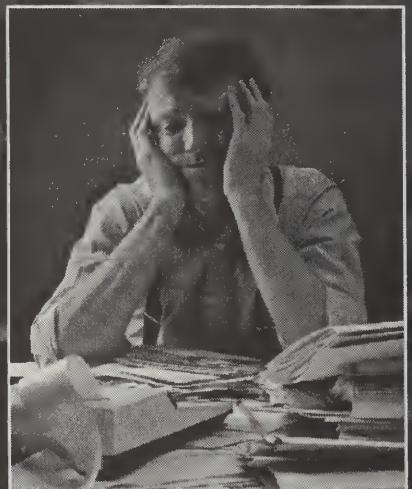
No matter how dire one’s current circumstances might appear, we usually don’t have to look very far to find someone else in equal or greater distress. Such is the nature of life and it isn’t always fair. Though we cannot control what happens to us all of the time, we do control how we choose to respond. We can control the lens through which we view the world and our individual surroundings. It’s kind of like seeing a glass as half empty or half full.

Cultivating a daily attitude of gratitude, in addition to our annual one day tradition, has a tremendously positive effect upon our world view and our responses to whatever environment in which we happen to be. Some days it is easier than others, but it is an important exercise to pursue on a regular basis. By pausing a few minutes each day to both reflect and express our thankfulness, we are much more likely to live life in an appreciative manner.

There are many things for which I am personally thankful. I am blessed by a loving family without whose support and assistance I could not do what I do! I am blessed with cherished friends who attempt to keep me straight! I am blessed to be associated with you, my physician colleagues in this state, whose exceptional dedication and service is unmatched! Most of all, I am blessed with the gift of life itself.

Have a great Thanksgiving each and every day!

Candace



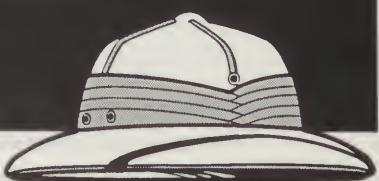
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Editorials

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
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CHRONIC BISCUIT POISONING

If it happened to me once last week, it happened to me fifteen times. Just try to go through a sack of medicines during an office visit. The alarmingly large bag becomes much smaller once the vitamin supplements, mineral pills and containers of root extracts, leaves, berries, grasses and shark cartilage are tossed aside. The follow up question after "Are these okay?" is often an inquiry into what else might be taken. It seems patronizing at that moment to point out the problem in Mississippi is overnutrition, not undernutrition.

In this issue of the Journal MSMA, Alan Penman, epidemiologist at the Mississippi State Department of Health, reveals the fact that 62% of Mississippians are overweight, up seventeen percentage points over the last decade. Most unsettling, young adults are some of the worst affected groups. Mortality statistics illuminate the seriousness of the epidemic; death rates are up to 25% higher in those overweight and up to 100% higher in the frankly obese (120% and 140%, respectively, of desirable weights).

In contrast, tobacco use, engaged in by some 25% of the population, tends to be treated more seriously by society (there are no warning labels on containers of butter, and the obese are not required to take their meals outside in January).

I used to warn patients about obesity the way I did about smoking—one or two mentions followed by resignation. Recently, IQH, the Mississippi Professional Review Organization, has started an anti-tobacco campaign emphasizing reminders and discussions with tobacco users at every office visit. Smokers average five attempts before quitting, and one or two proddings aren't enough. The same tact should be taken with the overweight. If we can instill even half the dread in obesity that people have in, for example, Lyme disease we will have saved Mississippians from a lot of misery. And chronic biscuit poisoning may become as feared as a heart attack.

—Leslie E. England
Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal MSMA.

DENIAL

“Mama’s got a real bad foot today, doc...
Her daughter said.
“It makes me sick to look at the thing.
We wondered why she took to laying on the couch last week
And why she didn’t go in to work at the cafe.”

On visualization
I see her great toe
The tip ... split and splayed...
Like a too-long microwaved hot dog
Bursting from its casing...
A foot unrecognizable
As human.

Ms. Mary ... surely you have not been up working
With a foot like this...
Have you?

“Yeah ... but I been a doctorin’ it.
I cut it while I was trimming my toenails the other night.”

“Which night was that, Mama?”
Her daughter said.
“You told us you showed it to the doctor
A month or so ago...
When you came in to get your sugar checked
And get your sugar pills.
You didn’t tell us a story
Did you?

“I didn’t want to miss work...
I t was gettin’ better, I thought...
I been puttin’ that neosporin stuff on it ever night...
It didn’t hurt that much, anyway...

Then...
Wanting to cry over this wretched-looking foot,
I ask...
Ms. Mary, WHY, WHY ... didn’t you tell me?
WHY didn’t you just ask me
To take a look at your foot
Last month
When we could have done something ?

“I thought I did, doc.
I guess I was in too big a hurry to get home
And cook supper.”

I supposed in retrospect
That was the day I rushed off to the clinic
Just out of the shower
With wet hair And ran off and left my crystal ball
And my X-ray vision glasses
On the counter top.

“Mama, I can’t believe it”...
Her daughter said.
“You nearly lost a toe
Five years ago...
You know how important it is
To tell somebody!”

“I didn’t really have a way to get here.
I didn’t want nobody to have to take off work on account of me.
I thought it was getting little better and it would be alright.”

Denial is bliss
For a while...
Then comes the hurried car ride
To the Surgeon who saved her other toe
Once upon a time.

He won’t save this one...
Or even the foot.
Too far gone.
There will be an amputation tomorrow
Would be my guess....
Then a long, slow learning to walk again...
....maybe.

Denial is a wonderful, powerful human defense mechanism
Which lets me get in my car every morning
And drive to the clinic with wet hair going 70
And never once doubt that I’ll get there
Alive.

And denial is the ultimate
Stealthy
Thief
Of human existence
Which allows Ms. Mary to ignore her dying flesh
Until she is too febrile to hold up her head
Until the stench can no longer be hidden
Until they take off her foot.

—*Dwalia South, M.D.*
MSMA Board of Trustees
Member, Committee of Publications

Letters

September 21, 2000

Editor
Northeast Mississippi Daily Journal
Tupelo, Mississippi

Dear Sir:

Each and every day I open one or more newspapers to painfully read yet another paid advertisement from a plaintiff's attorney actively seeking out patients who have used various FDA approved medications and who "may be entitled to compensation for damages caused by these medications". In each ad there follows a note of encouragement to the patient reader to... "call us today to protect your legal rights! ... no legal fees unless we collect for you".

The current "drugs of choice" for these law firms to attack are Rezulin and Propulsid. Rezulin was an extremely effective and often used drug for the treatment of Type II Diabetes, and Propulsid was a gastro-intestinal motility drug to enhance digestion and benefited countless thousands of patients. Like every other physician in this nation, I used these drugs extensively and to my knowledge none of my patients were ever harmed by them. However, in recent weeks our clinic has received calls from patients who after reading these ads have called to ask for their medical records. One patient who called said that she thought she may have received a prescription for the Propulsid about eight years ago and wanted us to look it up in her record, make a photocopy, and mail it to her lawyer!

I want to remind the readership that these drugs were rigorously tested by the Food and Drug Administration prior to their release for prescription availability to the public. As with all potent medications, the potential for great benefit also carries with it the potential for harm. People forget that any drug with significant effects also has significant side effects. Every time a physician prescribes a medicine to any patient there are risks assumed. I personally say a little prayer every time I order something as simple, though as potentially life threatening, as penicillin.

Today, a new pariah drug appeared in the ad section of the newspaper ... Stadol, a still FDA approved and available analgesic that has been commonly used for years in clinics and hospitals. I dare say, dear reader, that

if you went to your local emergency room tonight with a severe migraine headache, there is a good possibility that Stadol may be prescribed for you. Be advised that if you do "you may have a legal claim against the manufacturer Bristol-Myers-Squibb as a result of medical problems and addiction from the use of Stadol".

It now appears that every adverse event that occurs from taking medication prescribed for a patient, every unforeseen drug allergy, every medication side effect, every drug interaction with other pharmaceutical agents, and now every drug to which someone becomes addicted warrants another potential new opportunity for someone to "go for the gold" in yet another disgusting class-action lawsuit. Does anyone believe for a minute that it is the individual patient who stands to gain monetarily from these legal contortions?

This summer, I got a personal taste of what happens when a patient responds to one of these legal ads. I received notification that I was being sued along with about a hundred other Mississippi physicians for allegedly prescribing a medication which "may have caused harm to a patient". Dozens of these physicians are in the Tupelo-North Mississippi area and all of them are quite reputable and competent doctors that I know personally. I hope a few of them are reading this letter.

This horrendous four pound document arrived at my home on a Saturday morning. There were approximately five typewritten pages listing the names of patients who were doing the suing. Over a dozen pharmaceutical manufacturing firms were named as defendants as well as the hundred or so individual pharmacists who filled the prescriptions, and the drug stores where the medicine was obtained. The upshot of the thing was that the lawyers sought for each individual patient from the professionals who took part in their treatment (the prescribing physician, the dispensing pharmacist, and pharmacy) \$50,000.00 each. God only knows how much they were asking from the drug companies. The patient litigants are probably led to believe that the faceless, mega rich pharmaceutical firms are the only ones who will be paying for these proceedings. This is simply not the case.

I spent the remainder of that weekend sweating bullets and taking antacids, not being able to recall the patient who had named me in the suit. Come Monday morning at the clinic, I pulled her chart and was pleased to learn that I had indeed had not even prescribed the

medication that she apparently had told the lawyers she had received. The law firm in its haste apparently cut comers by not actually obtaining their clients' medical records and merely based their allegations on the patient's word only. I dare say that I suffered at least \$50,000.00 of physical and emotional trauma from this escapade. If I had been smart, I would have gone to the doctor with the migraine headache all this crap gave me, and asked for some Stadol so I could get a little money out of this deal for all my trouble!

Nonetheless, I of necessity had to report this wrongful suit to my malpractice carrier so they could get the mess straightened out. I am still receiving reams of pregnant appearing manila envelopes pertaining to this case each week. The pile is about 18 inches tall now and growing.

The sad question which should be asked is "just who exactly is paying for all this?" The even sadder answer is that WE ALL ARE PAYING FOR IT in terms of the further shifting of skyrocketing costs for drugs ... the pharmaceutical companies will have to make up for their losses somewhere and that will be by further raising the already grossly inflated prices of their products. Pharmacists' overhead will creep up a bit more. And because physicians' malpractice insurance premiums will increase in price to pay for all the defense work they

will have to do, the cost of an office visit will go up yet again as well.

Ultimately many health care providers will tire of fighting the daily battle of trying to practice good medicine while constantly watching their backs. It is a great emotional drain on a clinician or pharmacist to constantly be on the defensive about every medicine they give to every patient. Many will retire early or simply make a career change because of the growing hassle-factor. You can't ever tell, a few may enroll in law school.

What I'm asking readers to take away from all my rantings is this ... if you are intrigued by one of these class action lawsuit ads enough to consider responding to it, before you let the \$\$\$\$ signs roll too far up in your eyeballs, remember just who all you will be suing. You will not only be pointing your litigious finger at the big drug manufacturing corporations, you will also be suing, your pharmacist, your pharmacy, and your personal health care provider none of whom will entirely thrilled when you show back up on their collective doorsteps asking for health care in the future.

Most sincerely yours,

Dwalia South, M.D., FAAFP

Immediate Past President,

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Mississippi State Medical Association Alliance Will Sell Artist Ray Freeman, M.D.'s Christmas Cards

As a personal favor to Peggy Crawford of Louisville, Dr. Ray Freeman has donated approximately 1,000 of his beautiful Christmas cards to the MSMAA. Dr. Freeman's only stipulation was that all the proceeds go to the AMA Foundation Inc.

Mrs. Crawford met Dr. Rag Freeman, who was a friend of Dr Edsel Stewart of McComb, Mississippi, at a Southern Medical Association meeting. Drs. Stewart and Freeman share the talent of being gifted artists. Dr. Ray Freeman is from Hate Center, Texas, and he exhibits his art work at the Southern Medical Association meetings each year. He donated a previous set of Christmas cards to the AMA-ERF when Mrs Crawford was the National AMA-ERF Chairman in 1994-1995. Recently he contacted Mrs. Crawford again with a generous donation of a new set of Christmas cards that he has produced.

The MSMAA will be selling Dr. Freeman's cards in packages of 25 for \$20. You may ordered these lovely cards by sending the bottom portion of this page to Susan Rish, AMA Foundation, Inc. Chairman, P. O. Box 2483 Tupelo, Mississippi 38803. Make your check out to the AMA Foundation and as always this is a tax deductible donation.

Number of Packets of cards:times _____ \$20 = \$ _____ Total

Please mail cards to:

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“\$50 for the 50th” Southwest Airline Ticket Raffle

In honor of their valued employee, Christy Moran, andas a way of saying “thank you” for the daily contributions made to Southwest’s ongoing success, Southwest Airline’s representative Michele Chapman donated two positive space passes for roundtrip transportation between any two cities on Southwest’s system. These tickets will expire June 1, 2001. The Mississippi State Medical Association Auxiliary will sell raffle tickets beginning September 1, 2000 until November 30, 2000. The winner will be announced at the beginning of December in time for Christmas. Our slogan is “\$50 for the 50th.” The price of each raffle ticket is \$50 to commemorate the 50th Anniversary of the AMA Foundation, Inc.

To take a chance to win two roundtrip tickets to any Southwest Destination, simply complete the raffle section listed below. All proceeds will benefit the Golden “50th” Anniversary of the AMA Foundation, Inc. And as always this donation is tax deductible.



“\$50 for the 50th” Southwest Airline Ticket Raffle

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P. O. Box 2483

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MSMA President Receives Derrick Award



Alton Cobb, M.D., MSMA President Candace E. Keller, M.D., M.P.H.; David Schulke, executive president of American Health Quality Assurance (AHQA) and James S. McIlwain, M.D.

MSMA President Dr. Candace Keller has been named the recipient of this year's Arthur A. Derrick Memorial Award from Information and Quality Healthcare. The presentation was made by IQH president Dr. James S. McIlwain at the peer review organization's Quality Showcase 2000 held at the Jackson Medical Mall September 15.

Dr. McIlwain cited the contributions Dr. Keller has made to quality medicine, including her work through IQH where she became a clinical coordinator in 1994. An anesthesiologist from Hattiesburg, she has also served as assistant clinical professor in the Department of Anesthesiology at the University of Mississippi School of Medicine.

Dr. Keller has been instrumental in the quality

improvement projects carried out through the Health Care Quality Improvement Program and IQH. In addition to project development, she has also been pivotal in sharing information from the projects through numerous programs and through publications, including the *Journal of the Mississippi State Medical Association*.

The award is made annually in honor of the late Dr. Derrick, who played an important role in the support of quality medicine in the state, including working with a pilot review project, then the professional standards review organization which evolved into Mississippi Foundation for Medical Care/Information & Quality Healthcare becoming the federally designated PRO in 1984. Dr. Derrick served as a board member and as chairman. He died in 1993.

Updated Recommendations From the Advisory Committee on Immunization Practices in Response to Delays in Supply of Influenza Vaccine for the 2000—01 Season

Flu Vaccine Supply

The Department of Health and Human Services' Food and Drug Administration and Centers for Disease Control are working closely with vaccine manufacturers to facilitate the availability of safe and effective influenza vaccine for the upcoming flu season. On July 14, CDC reported a substantial delay in the availability of a proportion of influenza vaccine for the 2000—01 season and the possibility of a vaccine shortage.¹ Since then, resolution of manufacturing problems and improved yields of the influenza A (H3N2) vaccine component have averted a shortage. Although safe and effective influenza vaccine will be available in similar quantities as last year, much of the vaccine will be distributed later in the season than usual. This update, given mid-October, provides information on the influenza vaccine supply situation and updated influenza vaccination recommendations by the Advisory Committee on Immunization Practices (ACIP) for the 2000—01 influenza season.

For the 1999—2000 influenza season, approximately 77 million doses of vaccine were distributed, of which 3 million doses were returned. On the basis of information provided by manufacturers, distribution of approximately 75 million doses is anticipated for the 2000—01 season, including 9 million doses that CDC has contracted with Aventis Pasteur (Swiftwater, Pennsylvania) to produce. Most vaccine doses usually become available to providers by October, with 99% of distributed doses available before December; this year, approximately 18 million doses are expected to be distributed in December.

The optimal time to administer influenza vaccine is October through mid-November² to assure that vaccina-

tion occurs before there is substantial influenza activity. In any influenza season, vaccine should continue to be offered after November to persons at high risk for influenza complications; this will be particularly important in this season in which vaccine delivery is delayed. The effectiveness of this approach is supported by surveillance data from the past 18 years, indicating that seasonal activity peaked four times in December, four times in January, seven times in February, and three times in March.

Vaccination of persons aged ≥ 65 years substantially reduces influenza morbidity and mortality. For each additional million elderly persons vaccinated, CDC estimates that approximately 900 deaths and 1300 hospitalizations would be averted during the average influenza season (CDC, unpublished data, 2000). The health impact of individual seasons can vary widely on the basis of the size of the susceptible population, the prevalence of influenza infections, the type and strain of the predominating virus(es), and the match between the vaccine strains and those circulating in the community. The primary goal of influenza vaccination is to prevent severe illness and death from influenza infection and its complications. Although the severity of influenza seasons varies, an annual average of approximately 20,000 deaths and 110,000 pneumonia and influenza (P&I) hospitalizations result from influenza infections.^{3—5} More than 18,000 (>90%) of these deaths and approximately 48,000 of the P&I hospitalizations per year occur among persons aged ≥ 65 years who are at highest risk for influenza-related complications.

Because of the potential health impact of delayed influenza vaccine availability, CDC and ACIP updated

recommendations for the 2000—01 season. The goal of these recommendations is to minimize the adverse health impact of delays on high-risk persons. Minimizing the adverse impact on this group will require an effective response by the private and public sectors, including actions that have not been undertaken during past seasons.

Updated ACIP Recommendations for the 2000—01 Influenza Season

Persons at high risk for complications from influenza are:

1. persons aged ≥ 65 years;
2. residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions;
3. children and adults who have chronic disorders of the pulmonary or cardiovascular systems, including asthma;
4. children and adults who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (e.g., caused by medications or human immunodeficiency virus);
5. persons aged 6 months—18 years who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye syndrome after influenza; and
6. women who will be in the second or third trimester of pregnancy during the influenza season.

Other Updated Considerations

- When influenza vaccine becomes available, vaccination efforts should be focused on persons at high risk for complications associated with influenza disease and on health-care workers who care for these persons.
- Temporary shortages because of delayed or partial shipments may require decisions on how to prioritize use of vaccine available early in the season among high-risk persons and health-care workers; such decisions are best made by those familiar with the local situation. Vaccine available early in the season should be used to maximize protection of high-risk persons. Because vaccine supplies are expected to increase substantially in November and December, plans should be made to continue vaccination of high-risk persons and health-care workers into December and later.

- Mass vaccination campaigns should be scheduled later in the season as availability of vaccine is

assured. Based on projected vaccine distribution, in most areas campaigns will be scheduled in November or later. Efforts should be made to increase participation by high-risk persons and their household contacts, but other persons should not be turned away.

- Groups implementing mass vaccination efforts should seek to enhance coverage among those at greatest risk for complications of influenza and their household contacts. Strategies for targeting mass vaccination efforts at high-risk persons include 1) targeting announcements in publications and other media focused toward the elderly and those with high-risk medical conditions; 2) establishing liaisons with community groups representing the elderly and those with chronic diseases; and 3) offering vaccination to elderly relatives of persons in the workplace and employees.

- Special efforts should be made in December and later to vaccinate persons aged 50—64 years, including those who are not at high risk and are not household contacts of high-risk persons. Persons in this age group with high-risk conditions should be vaccinated along with other high-risk persons. However, special efforts to vaccinate healthy persons in this age group should begin in December and continue as long as vaccine is available.

- Vaccination efforts for all groups should continue into December and later as long as influenza vaccine is available. Production of influenza vaccine will continue through December, and providers should plan for how vaccine provided late in the season can be used effectively. Vaccination providers who administer all of their available influenza vaccine supply early in the season and who still have unvaccinated high-risk patients should order additional vaccine that will become available in December. To minimize wastage of influenza vaccine, providers whose initial vaccine orders are delayed or partially filled should not seek replacement vaccine from other manufacturers or distributors unless use of all vaccine doses ordered can be assured during the 2000—01 season.

- Pneumococcal vaccines are recommended by ACIP for many of the same high-risk persons for whom influenza vaccine is recommended^{6,7}. Assuring pneumococcal vaccination of high-risk persons in accordance with ACIP recommendations early in the season will confer substantial protection from a major complication of influenza (pneumococcal pneumonia).

- Annual influenza vaccination provides an opportunity to review the pneumococcal vaccination status of persons for whom pneumococcal vaccination is recommended by ACIP. This season, pneumococcal vaccine should be administered when indicated even if influenza

vaccine is not yet available. Providers should emphasize to patients or their caregivers that pneumococcal vaccination is not a substitute for influenza vaccination and that patients need to return for influenza vaccine when it is available.

Role of Health-Care Organizations and Health-Care Providers

ACIP encourages health-care organizations and providers to undertake special efforts to maximize influenza vaccine coverage among high-risk persons. Health-care organizations and medical providers that can identify elderly and high-risk patients from computerized administrative databases or clinical records should evaluate their capacity to send reminders directly to these patients. Reminder-recall systems have been proven effective in increasing vaccination coverage and are recommended by the Task Force on Community Preventive Services.⁸ In addition, ACIP recommends use of standing orders in long-term-care facilities and other settings (e.g., inpatient and outpatient facilities, managed-care organizations, assisted-living facilities, correctional facilities, adult workplaces, and home health-care agencies) to ensure the administration of recommended vaccinations for adults, including influenza vaccine.⁹ Assuring that elderly and high-risk patients receive vaccine before hospital discharge throughout the influenza season will provide protection for a large number of high-risk persons.

Role of State and Local Health Departments

State and local health departments can play a critical role in promoting vaccination of high-risk persons and in promoting ongoing vaccination through December and later. Because only a small proportion of influenza vaccine is delivered by the public sector, the greatest impact may be achieved through the formation of coalitions that include community and provider organizations to promote the strategies recommended by ACIP. Key coalition partners include professional societies, Health Care Financing Administration peer review organizations that have an existing focus on influenza vaccination through the National Pneumonia Project, and community groups that focus on high-risk populations. Many states already may have an active coalition for adult vaccination that could serve as a focus for state and local efforts. Health departments also can play a key role in disseminating timely and accurate local information on influenza activity and communicating local availability of vaccine to high-risk groups and monitoring and promoting vaccination of residents of long-term-care facilities.

Update on Use of Influenza Vaccine in Children

Early vaccination of young children with high-risk conditions is a priority because two doses of vaccine administered at least 1 month apart are recommended for children aged <9 years who are receiving influenza vaccine for the first time. Two influenza vaccines (Flushield™, Wyeth Laboratories, Inc. [Marietta, Pennsylvania], and Fluzone® split, Aventis Pasteur, Inc.) are licensed and recommended for use in high-risk children aged ≥6 months. One other influenza vaccine, Fluvirin™ (Medeva Pharma Ltd., Leatherhead, England), is labeled in the United States for use only in persons aged ≥4 years because its efficacy in younger persons has not been demonstrated. Because Fluvirin™ is not indicated for children aged 6 months—3 years, providers should use other approved influenza vaccines for vaccination of children in this age group.

This material and updates on the influenza vaccine supply will be posted on CDC's World-Wide Web site, <http://www.cdc.gov/nip>. Additional information and assistance can be obtained by contacting CDC's National Immunization Program by e-mail, nipinfo@cdc.gov, or the National Immunization Information Hotline, telephone (800) 232-2522.

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Information and Quality Healthcare- HCFA Quality Data

A new report from the Health Care Financing Administration (HCFA) shows us for the first time exactly which specific actions we can take to make good care even better.

Physicians across the country have already begun working on Medicare's national quality improvement projects. We are confident that by continuing to work together with the hospitals, patients, and quality improvement organizations in our communities, and if we all really focus on these specific areas, we can achieve significant improvement on these measures within a short period of time.

But these national projects are not the first time that physicians have worked with hospitals and PROs to improve quality. In fact, the six national projects grew out of a whole array of successful local and state quality improvement projects that served as pilots for the current national effort.

Even before the national projects began, in Mississippi for example, the state PRO worked alongside physicians and hospitals to increase the number of heart attack patients who received appropriate therapy such as "clot busters," ASA, beta blockers and ace inhibitors. Medical teams used expertise offered by the PRO to make changes to their systems that would increase the use of these proven drugs.

During the Fifth Scope of Work period, collaborative projects throughout Mississippi had already increased the use of processes of care delivered that would improve the outcome of illnesses. Now we are taking what we learned from these earlier projects as part of HCFA's new national effort and using it to make sure that our disabled and elderly patients throughout the state benefit from these projects.

These efforts in Mississippi are very similar to projects that physicians and hospitals have been participating in all over the country. For example, the AMA issued Quality Care Alerts to the nation's physicians on use of beta-blockers and pneumonia vaccines.

Like any improvement project, and this applies as much to home improvement or Olympic sports as it does

to the quality of medical care, it's difficult to move forward when we don't have the right tools. The new HCFA report provides an important blueprint to show us how to further improve the quality of care being provided to patients in the Medicare program.

This new study shows us exactly what changes we need to make if we want to make the American health care system, which is already considered by most to be the best in the world, even better.

U.S. life expectancy is longer than it has ever been, but if we can improve care processes identified in our projects, we may be able to extend life expectancy even further. Diseases that once killed are now fully curable, and others that were debilitating are now manageable, but we cannot just rest on our successes. For example, if we can make sure that patients with diabetes have their eyes examined regularly, or that patients with heart attack get the best medications, or that patients get preventive checks like mammograms, then we can improve quality of life even more.

But we cannot achieve success in these efforts unless we work closely with our patients. It's not enough for the Medicare program to cover mammograms for women and eye exams for patients with diabetes. It's also not enough for me to tell my patients to get mammograms and eye exams. My patients have to follow through in making appointments and getting these services if quality is really going to be improved.

This study also shows that no one element of the system—physicians, hospitals, patients, or quality experts—can make these improvements alone. We need to work together to make Medicare even better for this generation of seniors. . . . and the generation to come.

A summary of the project work carried out during the past year is the focus of the fall issue of the IQH newsletter Quality Matters. Every physician in the state should receive the newsletter. Please contact the IQH office, 601-957-1575, if you do not receive an issue.

— James S. McIlwain, M.D., IQH President



JoAnn Bienvenu, BSN

Here I go again! I'm going to talk about the issue of communication—again! I say this because I, and my fellow risk management consultants, hear the groans and sighs when we begin preaching communication and things like informed consent (groan, sigh). We hear the comments and read the evaluations.

“I've heard this before.”

“Same old song.”

“Do we have to listen to this again?”

Believe me, I would much prefer to discuss the more exotic risk management issues. Let me extol the virtues of a solid compliance plan. Give me an opportunity to strike fear into the hearts of office managers and medical records professionals with two words—“Privacy Act” (gasp!). Allow me to rage against the risks of e-medicine!

Alas, I must persist in addressing the same tired subject of “communication”? Why? Because our analyses of risk management issues associated with claims keeps coming down to just that issue. In the 1999 claims analysis published in our last newsletter, lack of communication/miscommunication was identified as a risk management issue in forty-one percent (41%) of the claims reviewed. This is up from 28% in 1998. Whether the problem is lack of informed consent, the “Who's in Charge” syndrome, or a systems breakdown in the flow of information, in the immortal words of Captain in the movie “Cool Hand Luke”:

“What we've got heah is failya to communicate!” Time after time, we see claims in which a seemingly isolated or insignificant breakdown in communication mushroomed into a full blown series of errors culminating in either a real or a perceived injury—and a claim or lawsuit.

Same Song, Second Verse

“An admitting physician asks the ED physician to order a consult to have the neurologist evaluate his elderly patient. The message that the patient is experiencing increasingly significant neurological symptoms never gets communicated. The patient is seen hours later as a routine consult, too late to successfully treat the CVA. No one is talking to the family members, who have become increasingly distrustful and hostile.”

“The family physician admits the patient for abdominal pain, and consults the general surgeon. The surgeon sees the patient, documents the consult on the chart, and hands the care over to her partner, the on call physician. The patient's condition worsens. The family physician assumes the surgeon is following up, the on call surgeon assumes the family physician, who admitted the patient, is responsible for the coordination of care, and the nurse has no idea who to call! The patient's condition continues to deteriorate.”

“The radiologist uncovers an unexpected finding on a routine chest X-ray. It is not his practice to personally call the treating physician in such cases, so he simply sends the report to the office. The office system breaks down, and the report is filed before the physician reviews and initials it. Two years later, the patient presents with an inoperable malignant chest mass which was seen on the original X-ray.”

Are these cases examples of clinical malpractice? Have these physicians simply “missed the boat” on diagnosis, just failed to treat because of negligence? Or are these cases in which the simple act of failing to communicate has deprived the physician of needed information, or failed to provide all the pieces of the puzzle to make an informed assessment and formulate a timely plan of care?

Solutions? Consider the following:

- Choose your staff. A good staff is essential in keeping the lines of communication open and developing and implementing systems which aid you in your clinical practice. The best clinician in the world cannot practice to peak efficiency in an environment of inefficiency. Be sure to communicate to your staff your expectations for the office. Keep the lines of communication open through staff meetings during which ideas are exchanged freely. And if your staff is valuable enough to work for you, they are valuable enough to listen to.

- Develop and implement systems. If you don't have a system, important things "fall through the cracks". Continue to evaluate your systems to assure they are being followed. If not, why not? Perhaps you need a new system. If "I" is the system, you have no system. Suppose "I" is not there? Written policies and procedures assure everyone knows what to do. Nothing elaborate, just straightforward and applicable to your practice.

- Written is better. Anything that can be in writing to assure better communication with your patients and with your staff will help. Instruction sheets, information sheets, practice brochures, informed consent forms to guide and document the process all help in improving communication among all involved. I know of one physician who writes each instruction he gives a patient down on a prescription pad, tears it off, and hands it to the patient. Let's face it, don't we all have to write ourselves reminder notes? How many yellow sticky notes do you have on your desk at this moment?

- Treat the family. I cannot overemphasize the importance of keeping the lines of communication with the family open and addressing their issues surrounding their loved one's care—keeping in mind the importance of confidentiality and the patient's consent for such communication. So many times the physician becomes so involved with treating the patient that he or she neglects the family concerns. No ongoing dialogue addressing these issues plus an unexpected outcome equals mistrust, doubt, and suspicion.

- "Slow done—you'll save yourself some time." This very wise piece of advice was shared with me by Dr. Stephen Tartt, a surgeon who knows that, sometimes, less is more. For surgeons, of course, this advice refers to surgical technique and the benefits of not getting in too big of a hurry. But this advice is valuable to all physicians. Sometimes you just have to say "enough is enough" and limit yourself. No one can cram every minute of the day,

working or personal, with things to do without making mistakes. No physician can see an endless stream of patients or perform what looks like assembly line procedures without giving out.

Well, once again, I've had my say! I've picked up the communication baton and run with it. For those of you who know me-- well, you know it won't be the last time I rant and rave. But, there's an old southern saying: "Silence isn't always golden. Sometimes it's just plain yellow".

JoAnn Bienvenu, BSN is director of risk management at Medical Assurance Company of Mississippi (MACM). MACM periodically features articles on risk management, legislation and current liability issues facing Mississippi physicians today.

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Wand of Aesculapius

Looking Back: A Unique Case of Obstetrics

Selected and edited by Lucius Lampton, MD, Associate Editor

[This month, we look back to a report published in the Transactions of the Mississippi State Medical Association, which was presented at the Thirty-fourth Annual Session, held at Jackson on April 8-10, 1901. It was written by widely admired physician Dr. Joseph W. Thomason of Arkabutla. Dr. Thomason was active both in the medical and civic communities, being one of Arkabutla's foremost citizens at the time of his death in 1908. He was buried in Surratt's Graveyard in Arkabutla. This community is located eight miles west of Coldwater in north Mississippi's Tate County. This month's report is a complicated case of obstetrics, which consumed much of the turn of the century physician's practice.]—Ed.

Mr. President and Gentlemen: —

I submit a brief report of this case on account of its variety of character, showing the wide range of departure from the normal, by which we sometimes are confronted. On the morning of March 10, 1898, I was called to see a negress two miles away, age 41 years, *enceinte* with seventh child as she said; had gotten along well from time of conception until three weeks prior to my visit, when she had pain in left side just inside of the spinous process of the ilium, which grew worse daily. From what I was able to elicit, patient was not quite five months in *utero-gestation*, though the very much enlarged abdomen was suggestive of plural pregnancy and an abundance of amniotic fluid at the end of full term, or even more than this, the uterine tumor was so pronounced, made an examination per *vagina* with unsatisfactory results, administered anodyne and directed that a position of *recumbency* be steadily maintained until my return a few hours later. Twelve hours from this time I saw patient again, when there was no improvement, and when not under the influence of an opiate more restless than on preceding visit; there was an apparent increase in size and tension in the few hours that had elapsed during my absence from the case; was still unable to detect the presence of the fetus except in a vague and unsatisfactory kind of way, had marked supra-pubic edema, which led me to diagnose excess of liquor amnii with death of fetus prior to extensive ossification; so dilated cervix, ruptured membranes, when there was an escape of liquor amnii much in excess of anything of the kind that I had ever observed.

The American Text Book of Obstetrics reports a case in which this fluid amounted to more than five gallons; the case under consideration was not so much outside of the fetal cranial sack and with it probably would not have equaled the twenty quarts reported by this authority. I encountered some difficulty in obtaining the fetus without rupturing the hydrocephalic sack, so large was it, containing a larger amount of fluid than any case of the kind that I had ever seen; however, I succeeded in doing so. Of course I expected bleeding due to atony from over-distension, and had some, but by the employment of Crede's method for most of the time for an hour together with strychnia and ergot, it was not great.

On return visit twenty-four hours later found patient doing tolerably well with the exception of a low temperature, 98 degrees F. Saw her no more for five days, when temperature was down to 97½ degrees F., with slight pain in left leg. If I mistake not it was Dr. Byars, of Belfast, that first called the attention of the profession to a low temperature as among the earliest of the prodromic phenomena of phlegmasia albi dolens due to migration of toxins. Twenty-four hours later saw patient shortly after she had had a chill, temperature 101 degrees F. with swelling of foot, which rapidly passed up to body, also pain in limb increased showing that thrombus began in the leg making the phlebitia form. The case was treated by elevating the limb, applying tincture of iodine along track of swollen veins, surrounding same with cotton batting, slightly compressing with roller bandages, that the reflux

of the venus blood might be encouraged, and at same time avert as much as possible congestion of the parts.

Painting with iodine was repeated at intervals of thirty-six hours; calomel, quinine with anodynes constituted the treatment. Lochia was diminished, but not entirely checked for four days, after which there was general improvement that continued until dismissed on the 15th day from initial chill.

There was some lameness following attack for twelve months or more. She has borne a healthy child at full term since recovery.

The noticeable features in this case are: Hydramnia, occurring about once in fifteen hundred instances of pregnancy; fetal hydrocephalous, once in five hundred, and phlegmasia albi dolens, once in five hundred and fifty. Should all appear in a single puerperium, besides, it has been claimed by some that the negro race is free from phlegmasia dolens.

Then, as intimated in the beginning of this report, there is no misnomer in the caption, "A Unique Case in Obstetrics."

— J. W. Thomason, M. D., Arkabutla
Transactions of the MSMA, 1901, pages 209-211

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Personals

Richard C. Boronow, M.D., Jackson, Mississippi, presented a paper "Endometrial Paper and Lymph Node Sampling: Short on Science and Common Sense; Long on Cost and Hazard" at the Felix Rutledge Society meeting (M.D. Anderson alumni) June 17 in San Antonio, Texas, and at the Society of Memorial Gynecologic Oncologists (Memorial Sloan-Kettering alumni) September 20 in Whistler, British Columbia.

Stanley Chapman, M.D., professor of medicine and director of the Division of Infectious Diseases, received the Distinguished Service Award from the Infectious Diseases Society of America at the group's 38th annual meeting Sept. 6 in New Orleans. Chapman served as chairman of the board of directors for the state and regional societies from 1997-2000.

Lyndon Perkins, M.D., a board certified pulmonologist with IMA-Tupelo Physician Office and medical director of the North Mississippi Medical Center Sleep Disorders Laboratory, has completed

education requirements for recognition as a diplomate of the American Board of Sleep Medicine. Perkins completed his medical training at the University of Mississippi School of Medicine and his internal medicine residency and pulmonary medicine fellowship at the University of Mississippi Medical Center.

David D. Madden, M.D. has joined the medical staff of Greenwood Leflore Hospital as anesthesiologist. Madden received his doctor of medicine degree and completed, the Anesthesiology Residency Program from the University of Mississippi School of Medicine. He is board certified in emergency medicine.

Jeff Lambdin, M.D., Jay Benson, M.D. and Mike Carter, M.D. of Mississippi ENT, affiliated with Greenwood Leflore Hospital, are pleased to announce the opening of their Greenville Office for the treatment of ENT disorders, located at 1502 S. Colorado Street in the Greenville Clinic.

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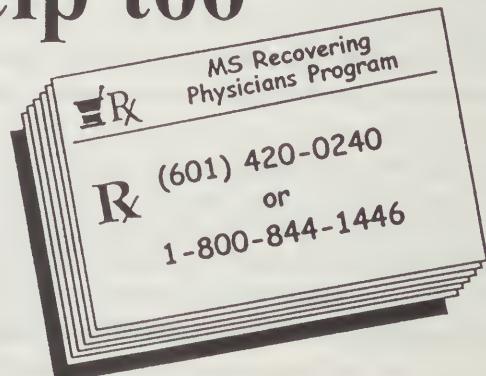
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Prayer in Medicine: A Survey of Primary Care Physicians

Keenan Wilson, M.D.
Lewis D. Lipscomb, M.D.
Kevin Ward, M.D.
William H. Replogle, Ph.D
Kathryn Hill, BS

A BSTRACT

Prayer and spirituality have been shown to have a significant impact on several health variables. Additionally, studies have shown that patients think prayer is important to their health. Very little research, however, has been done to determine primary care physicians' opinions regarding prayer and spirituality as it pertains to healthcare. We surveyed primary care physicians in Mississippi to assess their use of prayer in medical practice. Ninety-one percent of respondents considered prayer an important treatment modality, but 50.6% rarely or never discussed prayer with patients. Most who excluded prayer from clinical practice did so to avoid imposing their beliefs upon patients. A majority of primary care physicians in Mississippi recognize prayer as an important psychosocial variable in assessing and treating patients, but many are hesitant to incorporate this variable into the doctor-patient encounter.

Key words: Religion and Psychology
Religion and Medicine
Primary Health Care

INTRODUCTION

Increasing amounts of medical literature suggest that spirituality and religious commitment can have a positive effect on mental and physical health. A review of articles in the American Journal of Psychiatry and the Archives of General Psychiatry from 1978 to 1989 that used quantified religious measures showed that prayer, along with ceremony, social support, and relationship with God, were beneficial to mental health.¹ Pressman reported that among females who had suffered hip fractures, those patients who had strong religious beliefs and

practices had less depression and could walk further at hospital discharge than their less religious counterparts even when controlling for severity of fracture.² Lower blood pressure has also been associated with religious commitment.³ Even smokers to whom religion was very important were seven times less likely to have an abnormal diastolic pressure than those smokers who did not consider religion to be very important.⁴ An often-quoted study involving intercessory prayer for 393 CCU patients found that those patients who were prayed for were less frequently intubated, had less congestive failure, needed fewer diuretics and antibiotics, had fewer episodes of pneumonia, and had fewer cardiac arrests than those in the non-prayer group.⁵

Surveys published in the lay literature seem to highlight the growing interest that Americans have in prayer and spirituality as it pertains to their health. Time magazine reported that more than 80% of Americans polled believe in the power of personal prayer. The same poll revealed that 64% believed that doctors should join their patients in prayer if requested by the patient.⁶ This survey is consistent with Gallup polls that found over a 30 year period that approximately two-thirds of Americans agree that "My religious faith is the most important influence in my life."⁷ A similar survey published in *USA Weekend* suggests that the majority of people believe it is good for doctors to talk to patients about spiritual faith but only 10% recalled having had such a conversation with a physician.⁸

Despite the growing interest in prayer, spirituality, and religious commitment as it pertains to healthcare, very little research has been conducted to identify primary care physicians' ideas about the importance of

prayer in medicine or the frequency that it is used in their medical practice. Maugans and Wadland surveyed 115 family physicians in Vermont and discovered that a majority of those surveyed acknowledged the utility of prayer but infrequently inquired about prayer.⁹ This study sought to expand this questioning of primary care physicians regarding religious commitment and the use of prayer as an appropriate medical intervention.

METHODS

A one-page questionnaire was mailed to 753 primary care physicians in Mississippi. The sample included community-based family physicians who were active members of the Mississippi Academy of Family Physicians and internal medicine and obstetrics/gynecology physicians who were affiliated with the Mississippi State Medical Association. Respondents provided demographic data including age, gender, religious affiliation, and frequency of church attendance. They were asked dichotomous questions concerning the role of prayer in their personal lives, the role of religion in their approach to life, and whether they considered prayer to be an important treatment modality. Using a five-point Likert-type scale, respondents indicated how often they: (1) inquire about patients' opinions regarding prayer as a treatment modality, (2) pray for their abilities as a physician, (3) pray for their patients, (4) pray with their patients, and (5) discuss with their patients other sources of prayer such as family members or clergy. Reasons for not addressing prayer were also assessed.

RESULTS

Of the 753 surveys sent, 358 were returned for a response rate of 47.5%. The physicians returning surveys included 225 (62.8%) family physicians, 65 (18.2%) internists, and 68 (19%) obstetricians/gynecologists. There were 309 (86.3%) male respondents. Ninety-one percent of those physicians who returned the survey considered prayer to be an important treatment modality. Slightly more, 92.4%, considered prayer to be an important aspect of their personal life with 68.5% claiming that their entire approach to life is based upon their religion.

No statistically significant difference was noted among the three specialties regarding religious commitment and use of prayer in personal life or medical practice. The mean age of the respondents was 48.8 years and most (78.9%) attended church at least once a week. The religious affiliation of those surveyed was consistent with Mississippi demographics compiled from the 1990 census and is summarized in Table 1.

The extent to which prayer was used in the medical

practices of the respondents is summarized in Figures 1-5. Most respondents at least sometimes prayed for their abilities as a physician (91.6%) and prayed *for* their patients (89.1%). The majority discussed sources of prayer other than themselves with their patients at least sometimes. On the other hand, over half of respondents rarely or never inquired if their patients consider prayer to be an important treatment modality. Furthermore, almost three-fourths rarely or never prayed *with* their patients. Table 2 lists the reasons the physicians did not address issues of prayer with their patients.

DISCUSSION

This study shows that primary care physicians in Mississippi strongly agree with the public that prayer is an important treatment option, but many still hesitate to incorporate this variable into the doctor-patient encounter. Prayer is an important aspect of their personal lives (92.4%) and almost 70% agree that their whole approach to life is based upon their religion. The latter statistic closely parallels that of the United States public in previously cited surveys.⁷ These physicians also use prayer in their medical practice to some extent—mainly by praying for their abilities as a physician, praying *for* the patient, or by offering a “spiritual referral.” Even though previous research indicates that patients want their doctors to address spiritual issues with them,⁸ many physicians still fear imposing their personal religious beliefs. They are also concerned that their patients would be uncomfortable discussing issues of prayer and religion. These results are consistent with previous comments by physicians surveyed.⁹ The next most common reason given for not addressing prayer with patients is that the physicians do not think about it while with a patient. Many medical schools do not teach ways to incorporate a patient’s spirituality and religion into routine healthcare. This may limit how often these issues actually come to mind when a physician is with a patient.

Addressing issues of prayer, religion, and spirituality is consistent with the widely accepted wholistic approach to medicine. Additionally, in a time of growing disillusionment with many aspects of contemporary medicine and an ever-present concern for the declining value of the healthcare dollar, any cost-effective therapeutic modality should be a welcome adjunct to medicine. If patients believe in prayer as a therapeutic modality and prayer has been shown to have a positive effect on health, then physicians should be attentive to these issues. In fact, one could argue that physicians are obligated to do so.

Table 1

Religious Affiliation of Respondents

(n = 358)

Baptist	38.0%
Methodist	22.9%
Presbyterian	11.0%
Catholic	7.9%
Episcopal	5.4%
Church of Christ	3.7%
Agnostic	1.1%
Lutheran	1.1%
Mormon	0.8%
Christian Science	0.6%
Jewish	0.6%
Pentecostal	0.3%
Other	6.5%

This study shows that, in fact, many physicians are interested in these issues as they pertain to their patients. The majority of them, however, out of concern for their patients, have chosen not to address these issues directly with their patients. Increased awareness to patients' beliefs regarding these issues may alleviate some of the physicians' concerns. Equipping physicians with the necessary tools to incorporate effectively a patient's spirituality into the doctor-patient encounter may allow physicians to discuss these issues with more confidence. Learning how to talk to patients about prayer and religious issues could begin at the medical school level when students are introduced to clinical medicine and taught how to elicit a complete medical history. A very useful tool for this is the SPIRiTual History by Maugans.¹⁰ A patient's spirituality, religious background, and prayer life are extremely personal and often difficult to approach in conversation. Including a brief spiritual history as part of the routine work-up of a patient, however, can be quick, non-judgmental, and non-imposing. The information gained could relieve fears a physician may have regarding these issues, may open doors to a deeper understanding of the patient, and may have a positive impact on the health of that patient.

This study is limited by its ability to be generalized to all physicians because the results are based upon returned surveys only. There is the possibility that the physicians who returned surveys were those who most agreed with or believed in the use of prayer in medicine. Also, Mississippi lies in a geographical region histori-

Table 2

Reasons Physicians Did Not Address Issues of Prayer in Their Medical Practice

(n = 358)

I don't want to impose my beliefs upon someone else.	59.5%
My patients would feel uncomfortable.	21.6%
I do not think about it.	21.6%
I am not religious.	18.9%
I have not received appropriate training.	10.8%
Prayer has not been scientifically proven to be beneficial to health.	8.1%
I don't have time.	5.4%
I don't think it's important.	5.4%
Other	18.9%

cally referred to as the Bible Belt. This could influence how the data can be interpreted. The results of this

study, however, are consistent with those published in the previously mentioned study of physicians in Ver-

Figure 1.

Do you pray for your abilities as a physician?

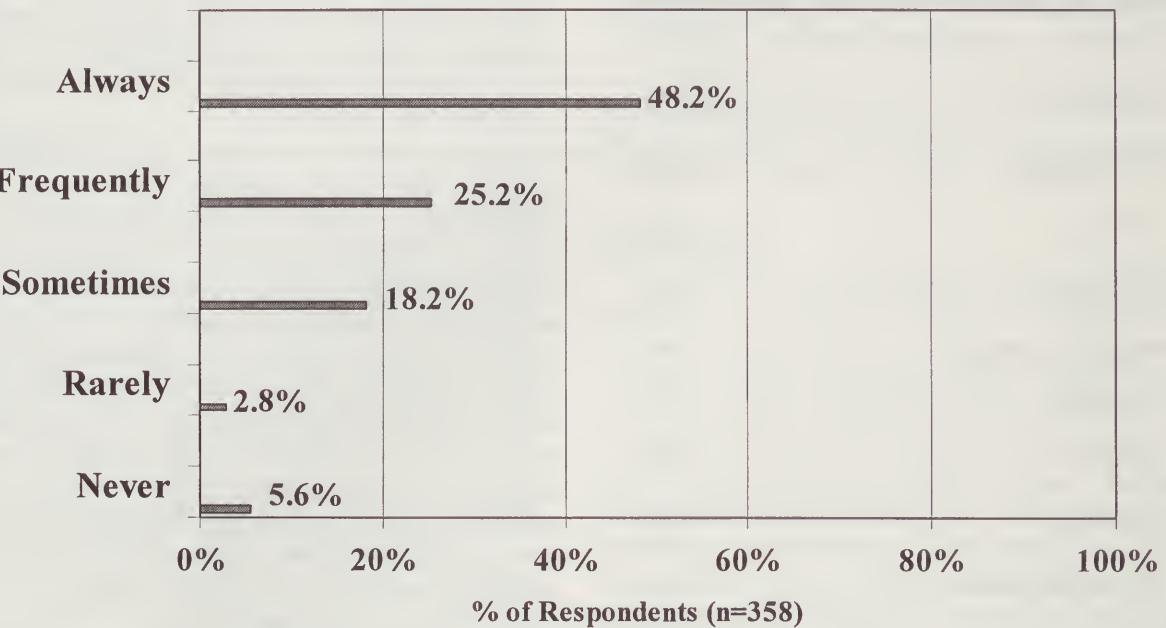
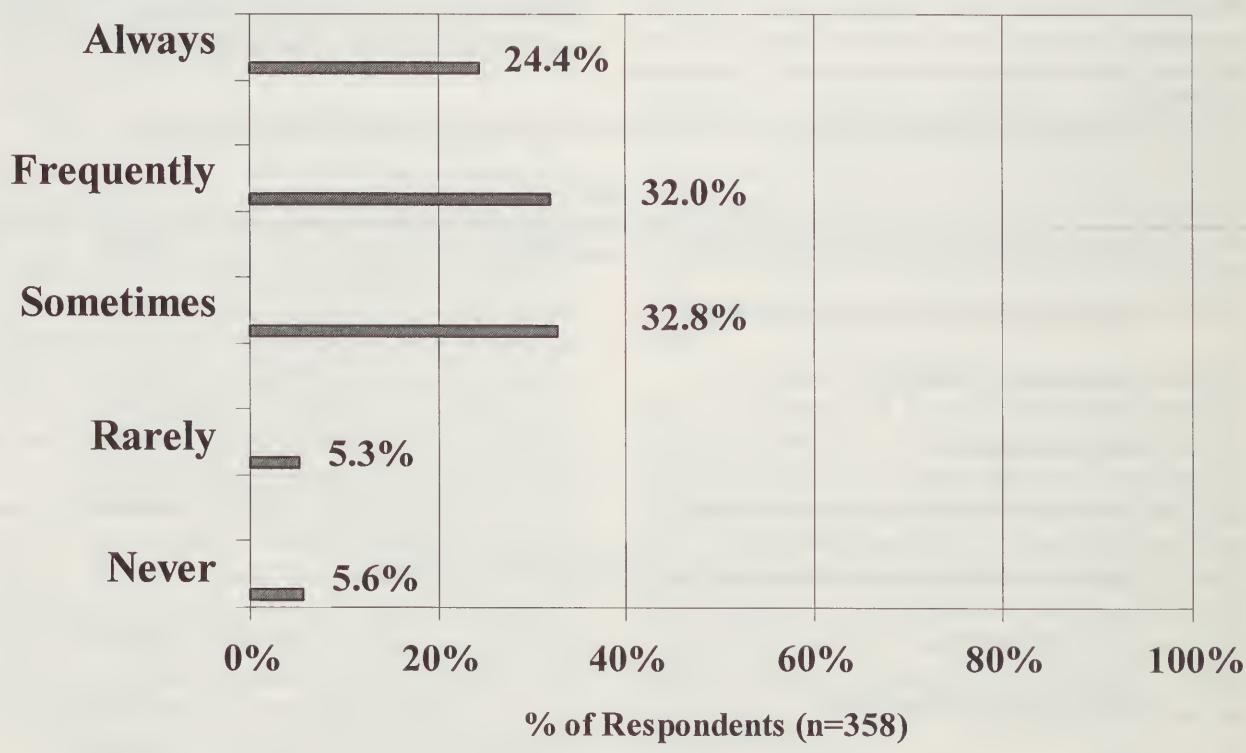


Figure 2.

Do you pray for your patients?



mont, which is a different geographical region.⁹ Other important future research should include surveying the

opinions and practices of pediatricians regarding issues of prayer. Also, longitudinal studies are needed to deter-

Figure 3.

Do you inquire if your patients consider prayer to be an important treatment modality?

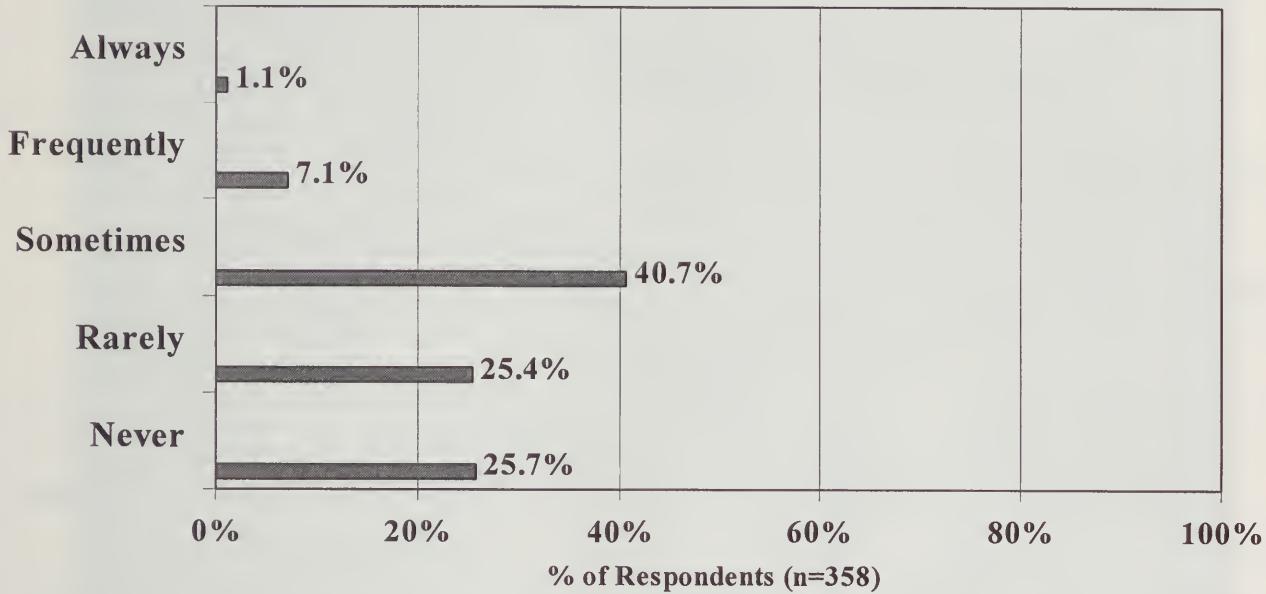


Figure 4.

Do you discuss sources of prayer other than yourself with your patients?

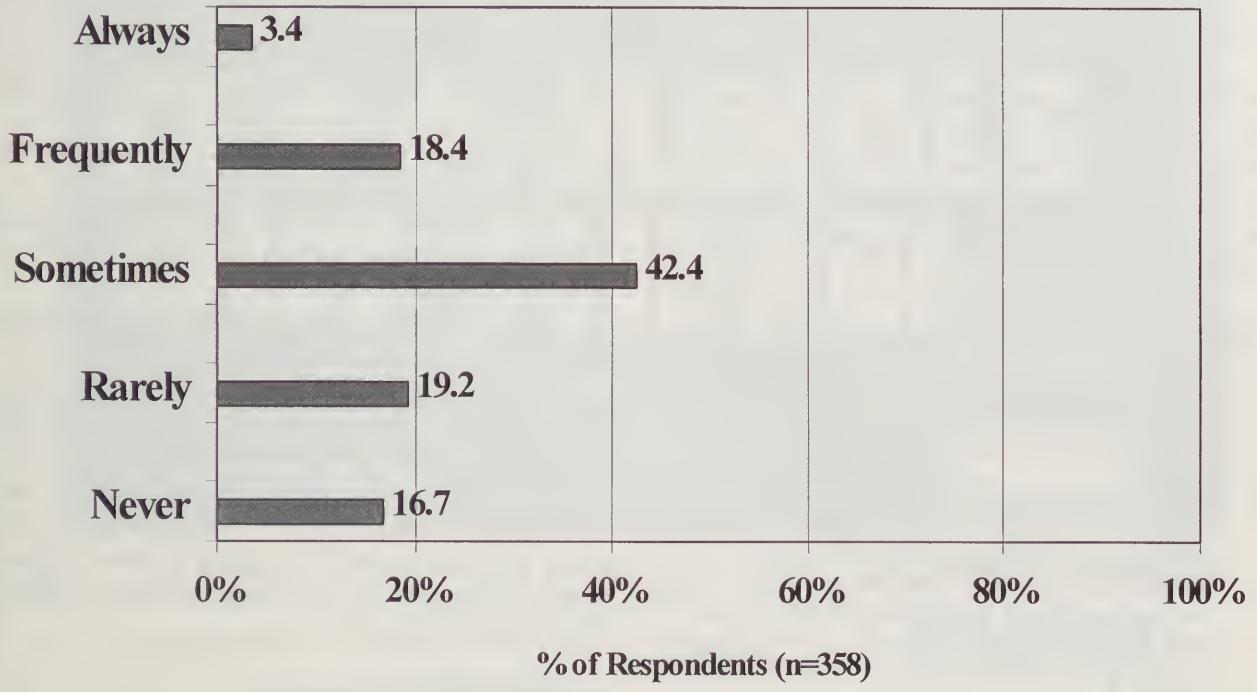
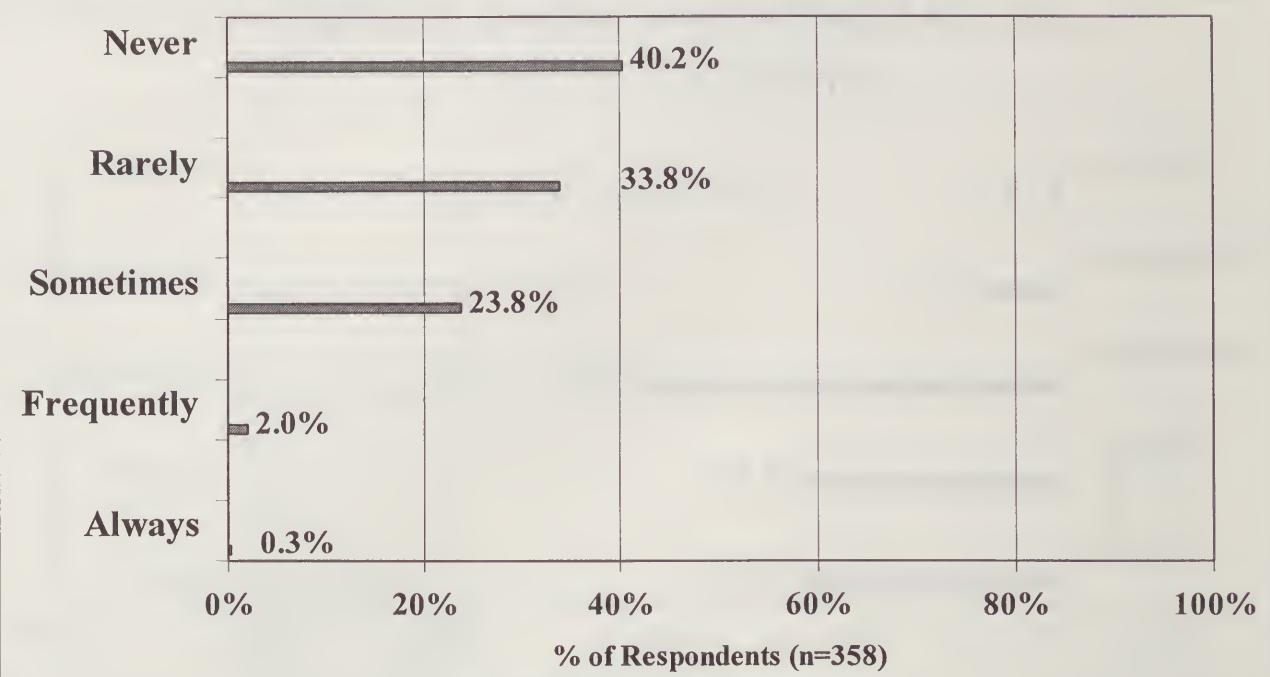


Figure 5.

Do you pray with your patients?



mine if discussion of prayer by a physician actually leads to improved patient health, as well as, continued research to determine situations in which prayer has the most benefit to health.

Acknowledgements

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Thanks, also, to Nancy O. Tatum, M.D. Due to her untimely death, she was unable to approve the final draft of this article; therefore, she is not listed formally as an author. However, I would like to acknowledge her vital participation in all other aspects of this project. Her devotion to her patients and to her students should be an example to us all.

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Dr. Wilson is a family physician in private practice in Winona, MS.

Dr. Lipsomb is a resident in the Department of Obstetrics and Gynecology at Wake Forest University School of Medicine.

Dr. Ward is a surgery resident at Carraway Methodist Medical Center in Birmingham, Alabama.

Dr. Replogle is Professor and Director of Research with the Department of Family Medicine, University of Mississippi Medical Center

Ms Hill was formerly a research associate with the Department of Family Medicine and is now a Library Information Specialist in the Department of Academic Information Services at the University of Mississippi Medical Center.

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Image-Guided Endoscopic Sinus Surgery

C. Ron Cannon, MD

INTRODUCTION

Endoscopic sinus surgery has become a gold standard in the surgical management of paranasal sinus disease. Although it is one of the most commonly performed procedures in Otolaryngology-Head & Neck Surgery, it is associated with a definite risk for intraoperative complications. These complications consist primarily of bleeding and damage to the orbit or to intracranial structures. As technology has evolved, computer-enhanced imagery has been utilized in a number of fields. This technology now is available for performance of endoscopic sinus surgery. It has the potential of decreasing potential complications related to sinus surgery by allowing the surgeon to verify this position within the paranasal sinuses at all times. It is the purpose of this paper to review the author's recent experience with an image-guided technique of performing endoscopic sinus surgery. As technology has evolved other systems are now available which are available in most community hospitals. These systems supply a visual image in the OR and allows precise localization of surgical instruments in the operative field.

The first use of computer type systems was in the field of Neurosurgery. In 1976, a helmet-like, plastic fixation device was utilized in conjunction with a CT scan, and subsequently allowed a limited intracranial instrumentation. These early types of stereotactic surgery were characterized by a rigid frame, which was attached to the patient's head.¹ The use of frameless stereotactic systems was first reported in 1986, using fiducial markers taped to the patient's head. In 1991, the ACHEN Hospital

in Germany reported on computer-assisted surgery, including nasal/paranasal sinus surgery, orbital tumors and skull base procedures.² The first report of computer-assisted endoscopic sinus surgery in this country was reported by Anon in 1994, using this technique in seventy different procedures.³

MATERIALS & METHODS

A retrospective review of the author's surgical registry for the time period 1 September 1998 through 30 September 1999 was obtained. During this time period, 113 patients underwent sinus surgical procedures at a single hospital with computer-assisted endoscopic sinus surgery availability. Of the 113 patients, 4 patients were felt to be suitable candidates for use of the image-guided endoscopic technique. (Table I)

Table I

Demographics of Patients Undergoing Image-Guided Endoscopic Sinus Surgery.

Patient	Age	Sex	Indication
1	15	M	orbital abscess
2	47	F	revision sinus surgery
3	52	F	recurrent nasal polyps
4	51	F	recurrent nasal polyps

The device used is the Insta-Trak manufactured by Visualization Technology Inc. in Boston, Massachusetts.

Technique

The Insta-Trak System is a device utilized for intraoperative image-guided endoscopic sinus surgery. It uses an electromagnetic tracking technology and provides the real time position of a suction instrument within the nose or paranasal sinuses, based on a preoperative CT scan while wearing a headset with fiducial markers.

On the day of surgery, the patients report to the Radiology Dept. in the hospital for a preoperative CT scan. While undergoing this axial CT scan, the patient wears a headset with fiducial markers continued within the helmet. (Figure 1)



Figure 1. Headset containing fiducial markers worn by the patient during pre-op CT scan and also intraoperatively.

After the CT scan is obtained, the patient is taken to surgery. Once the patient is anesthetized, the headset is applied and coupled to the Insta-Trak software system. The position of a suction device is verified and the procedure begins. (Figure 2) The positioning of either a



Figure 2. Straight and angled suction devices with special "bead" (arrow) which allows precise instrument localization within the sinuses. Further technology refinements will also allow tracking of various surgical instruments within the sinuses.

straight or angled suction device is then localized on a television monitor in a simultaneous coronal, sagittal and axial planes. Another quadrant of the television screen can be used for visualization of the area currently being operated upon. (Figure 3)

COMMENT

The use of fiberoptic endoscopes which allow more thorough examination of the nose, nasal cavities and nasopharynx coupled with the use of the coronal CT scan has markedly improved the knowledge and understanding of the anatomy of the sinuses. Endoscopic sinus surgery has become the procedure of choice for patients undergoing sinus surgery. Although unusual, major complications of endoscopic sinus surgery, including orbital hematoma, visual change, CSF leak and even death, have been reported.⁴

The potential advantages of an image-guided endoscopic sinus surgery are improved results and decreased complications.^{5,6} In a review of four different

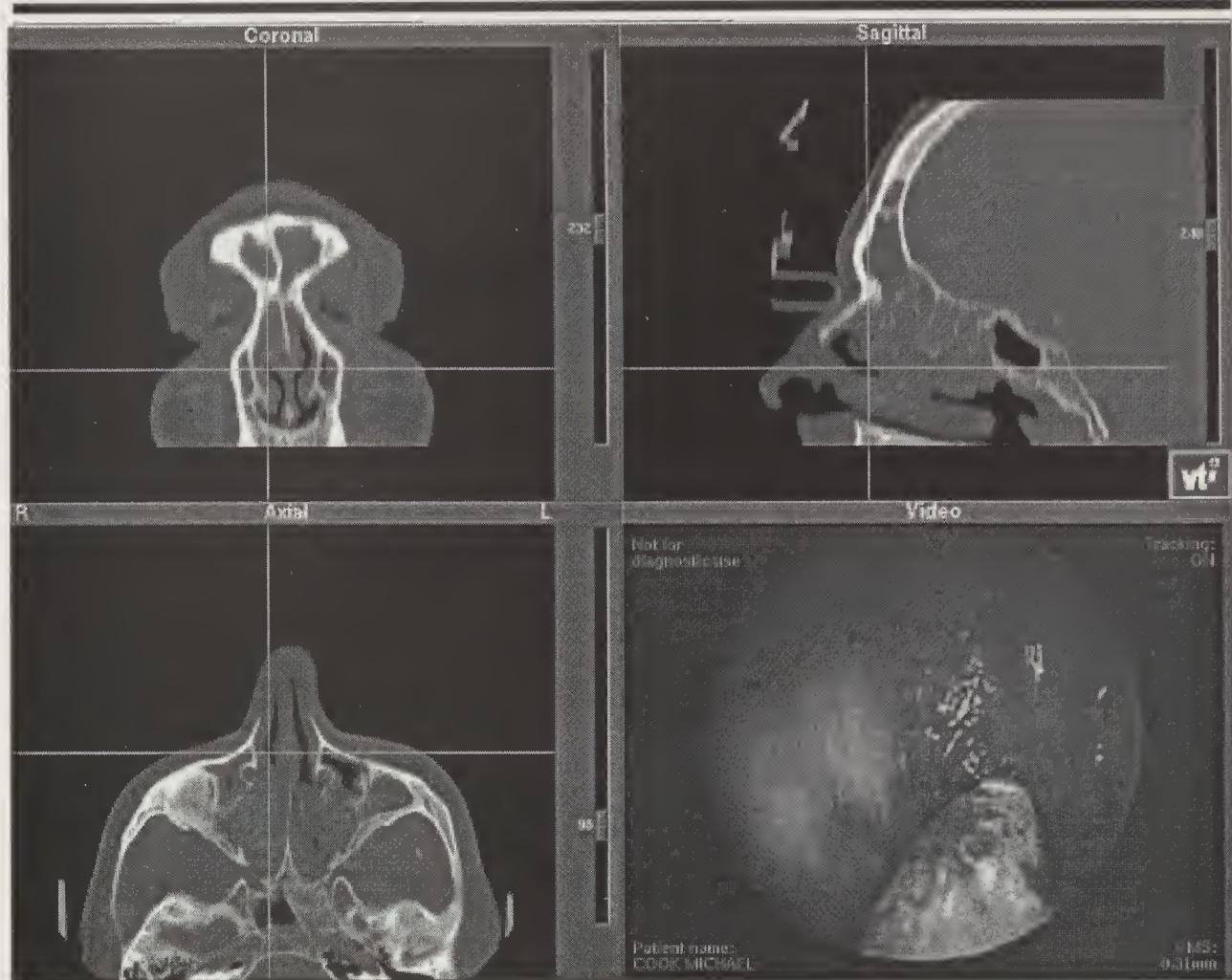


Figure 3. Visual monitor which allows tracking of surgical suction in several different surgical planes. A video camera can be attached to the operative endoscope and allow visualization on the screen also.

computer-aided imaging systems by Anon, the system accurately and reliably matched the actual location of the probe tip on the computer screen.⁶ Although there is a learning curve associated with use of this technology, it is generally perceived as being user-friendly and easy to become familiar with. A computer-aided system with a video camera attached to the endoscope becomes an ideal teaching school.⁷ This technology can demonstrate to the student appropriate anatomy both visually and in the CT scan format.

Some have advocated using this technology on each case; however, the author has not found this necessary. In my 13 years of endoscopic sinus surgery operating experience, there have been no complications of orbital damage, hemorrhage or penetration into the intracranial cavity causing a CSF leak. Current indications for use of the Insta-Trak device are those of orbital abscess, patients undergoing revision sinus surgery (par-

ticularly those in whom a portion of the middle turbinate has been removed), patients with recurrent polyps, such as Francis triad (nasal polyps aspirin-sensitivity and asthma), sphenoid sinus disease, frontal sinus disease, or other unusual anatomic problems which might be aided by an intraoperative image guidance system.

Another potential use of this technology is that of intranasal endoscopic tumor resection.⁸ (Table II) Fried et al have demonstrated that the surgeon's confidence level is enhanced when using this technology.⁵ The potential down side to use of this technology is the expense of the system itself. Currently, these systems cost in excess of \$100,000. There is also the need for an additional CT scan (axial) prior to surgery. A coronal scan is required for accurate diagnosis and planning of surgery. This system also increases operative time as the Insta-Trak device must be applied and calibrated. If the suction tip is changed during surgery, for example going

Table II

Indications for Image-Guided Endoscopic Sinus Surgery.

The following are relative, but not absolute indications for consideration of use of the procedure.

1. Orbital abscess
2. Revision endoscopic sinus surgery
3. Recurrent nasal polyps
4. Sphenoid sinus disease
5. Frontal sinus disease
6. Unusual sinus anatomy
7. Selected tumors

from a straight to curved suction tip, the system must be recalibrated. The need-for a headset could compromise an external approach.⁹ A final potential disadvantage of this system is that it might encourage the inexperienced surgeon to be too aggressive when performing endoscopic sinus surgery. (Table III)

Table III

Disadvantages of Image-Guided Endoscopic Sinus Surgery

1. Expense of the system.
2. Requires additional CT scan (axial) prior to surgery.
3. Headset is uncomfortable.
4. Added operative time to calibrate the system.
5. Possibly compromising an external surgical approach to the sinuses.
6. Might encourage the inexperienced sinus surgeon to become too aggressive.

There has been some concern about the accuracy of the image-guided systems when compared in vitro to the actual clinical setting. The main overall placement error was tested, comparing the image-guided system versus actual location on dried skulls. The average overall error was found to be 0.35 mms. Accuracies of 2.0 mms. or less are generally obtained in the clinical setting.⁶

Summary

This paper has described a new technique of image guided endoscopic sinus surgery. Being able to define the exact location within the sinus using CT scan while in surgery with the patient has the potential to enhance the procedure's utility and decrease the overall potential complication rate. Use of this technology, however, is not a substitute for a thorough knowledge of the anatomy of the paranasal sinuses or experience in performing endoscopic sinus procedures.

Further evaluation of this image-guided technology and experience with it will further define usage parameters in the future.

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C. Ron Cannon, M.D. specializes in diseases of the ear, nose and throat; head and neck surgery and oncology and facial plastic surgery.

Address correspondence: C. Ron Cannon, M.D.

Head & Neck Surgical Group
1038 River Oaks Drive
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Spain's Majesty: Our Opportunity

MSMA and MHA to Host Preview Gala for Members and Legislative Guests

Susan Nelson Pickard

MADRID, Spain — I wouldn't want the job of besting the wildly successful Splendors of Versailles exhibit of 1996 or 1998's Palaces of St. Petersburg which together attracted over 825,000 visitors to Jackson. Once the bar reaches a certain level, a repeat performance seems unattainable, beyond replication. So what can the Mississippi Commission for International Cultural Exchange possibly offer in 2001 to compare to the previous exhibits that have won international acclaim?

The answer is The Majesty of Spain, art and artifacts from a country with inextricable ties to North America, but one which is generally enigmatic to most Americans. The curiosity factor can be a big draw. If asked to conjure images of Spain, one might generate a bull fighting ring, some religious icons and maybe a flamenco dancer or two. But Spain is so much more. The challenge is to convey the grandeur, the significance, the majesty of Spain to hundreds of thousands who will never personally visit the nation whose financial and military support during the American Revolution was critical to our fledgling country's victory in the war for independence.

The next step involves having the audacity to ask really important people for the unthinkable. For instance, imagine asking the keeper of Spain's national heritage, "Could we borrow for six months the most important neoclassical painting in all of Spain? Would you mind if we exhibited that 55-foot gondola even though transporting it will be a logistical nightmare being the largest national treasure to ever be shipped transcontinentally?

And could we possibly display priceless Spanish artifacts that have never been out of the room in which they are displayed, much less out of your country? Oh yeah, and we want to re-create a couple — make that five of your most spectacular palace rooms and even keep two permanently ensconced in the Mississippi Arts Pavilion."

I personally would consider questions of that nature grounds for revoking one's passport. So on a recent trip to Spain to preview the exhibit, I asked the Dr. Javier Morales, Comisario for the Patrimonio Nacional charged with preserving Spain's royal national treasures, why he felt compelled to relinquish these priceless relics for a time to anyone and why us. "It is because of Spain's integral ties to your land — your nation and specifically the South. Notice the Spanish names for your cities and counties. When the American revolutionaries were fighting, our King immediately recognized U.S. independence and lent financial and military aide at great expense to our national treasury. However, Spain is not very well known in your area. We want to highlight our common roots, our glorious joint histories. We also considered that the Mississippi Commission for International Cultural Exchange has great experience in this type of exhibit and enjoys a high degree of financial, political, social and media support for its endeavors."

Thanks to our historical successes, distant and recent, Mississippi will be privy to the largest collection of Spanish royal treasures ever to visit North



An English-speaking guide from the Casita del Principe at El Escorial (left to right) looks on as Dr. Javier Morales, Comisario for the Patrimonio Nacional, and Jack Kyle, Executive Director for the Mississippi Commission for International Cultural Exchange, explain the process of recreating the Hall of Stuccoes for the Mississippi Arts Pavilion.



An artist for the Spanish restoration company El Barco paints the delicate medallion replica to be installed in the ceiling of the Porcelain Room will be preserved in the Mississippi Arts Pavilion after The Majesty of Spain Exhibition closes.



The Porcelain Room

The Royal Palace of Aranjuez, 1761-1763 One of only two porcelain rooms in the world, this amazing room is completely covered in flat, white porcelain panels with thousands of raised relief porcelain Chinese figures climbing the walls and adorning the ceiling.

America, the first major loan exhibition of the royal palaces of Spain and the first collaboration between the world-renowned Prado Museum and the Patrimonio Nacional. The Majesty of Spain Exhibition is the result.

THE ROOM RECREATIONS

As in the manner to which Jackson exhibit-goers have become accustomed, The Majesty of Spain will feature five spectacular room recreations from various palaces in and around Madrid. The centerpiece room will be the Porcelain Room from the Royal Palace of Aranjuez. The walls and ceiling are completely covered in flat, white porcelain panels and elaborately decorated with painted and gold-leafed porcelain reliefs of Chinese images. Our recreation is executed in resin, but is no less spectacular. This room denies description so it must be experienced in person.

Rivaling the Porcelain Room may be the Hall of Stuccoes from the Casita del Principe at El Pardo. The walls of this room are made of varying colors and levels

of faux-marble called scagliola meticulously made by hand in the centuries-old method. The process is akin to building walls with marble-colored Play-doh. The result is breathtaking as are the exquisite high relief sculptures which add more dimension and interest to the room. At the end of the exhibit, these two rooms will be preserved in the Arts Pavilion for the enjoyment of future generations.

The Tapestry Room will feature ten tapestries and their corresponding "cartoons" painted by Spain's Francisco de Goya, probably the best-known artist in the exhibition. The cartoons were used as guidelines for the weavers who transferred the painted images to cloth. The most famous of these paintings is "El Quitasol," (The Parasol) which will join the other cartoons and tapestries in their first ever exhibit outside Spanish borders.

The neoclassical Sculpture Gallery will house several ancient Roman busts and numerous other important sculptures. Finally, in the banquet hall, a table fit for a king will show off more than 200 pieces of royal porcelain, crystal, silver and gold.



The Sculpture Gallery - The Royal Palace of Madrid

This impressive neoclassical room will feature ancient busts and sculptures from the Prado Museum and the Patrimonio Nacional's collection.

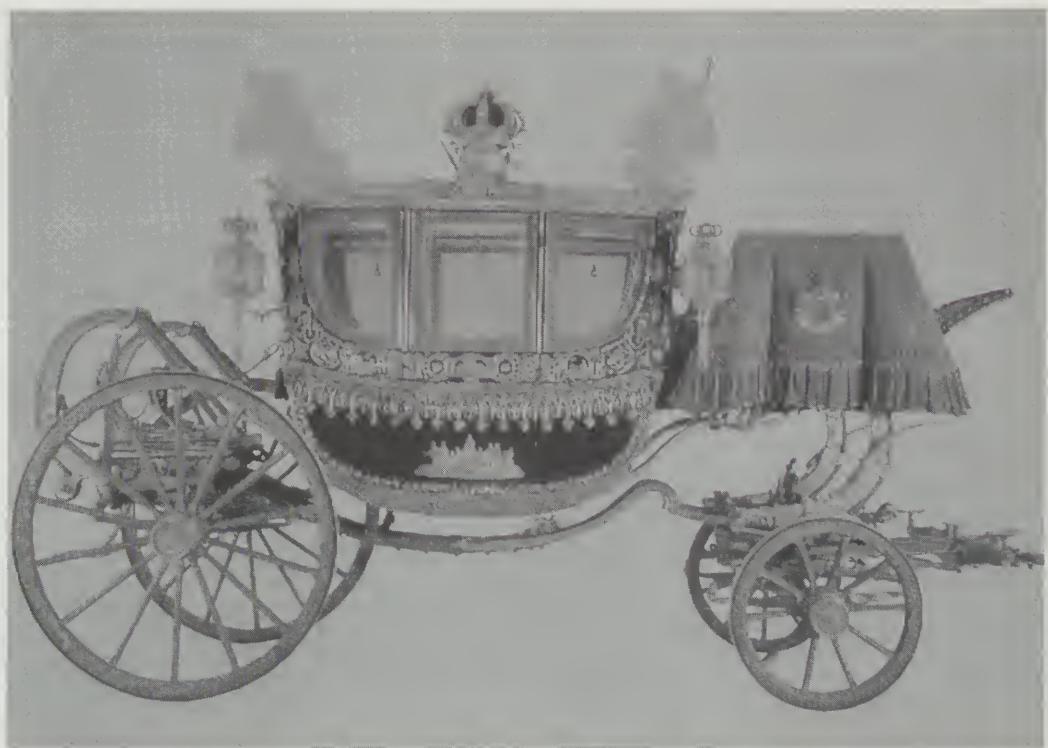


The Sculpture Gallery - The Royal Palace of Madrid

This impressive neoclassical room will feature ancient busts and sculptures from the Prado Museum and the Patrimonio Nacional's collection.



Artists from the Barge Museum at Aranjuez apply \$100,000 of gold leaf to this 17th century gondola in anticipation of its upcoming journey across the ocean to Jackson.



The Royal Carriage of Fernando VII - 1832

One of the largest objects in the exhibition, this exquisitely decorated carriage will be displayed with eight life-size horses and period-dressed livery.



El Quitasol (The Parasol)

Francisco de Goya, oil on canvas, 1777 *El Quitasol* is one of Goya's most famous cartoon paintings and one of The Prado Museum's most prized works. This masterpiece will be exhibited for only the first three months of The Majesty of Spain Exhibition due to its popularity at The Prado.

THE PAINTINGS

Three royal court painters' works will be exhibited in The Majesty of Spain Exhibition featuring paintings easily recognizable to those with even limited art exposure. In addition to Goya's tapestries and cartoons, his portraits of the royal family will be displayed including the famous "Hunting Portrait of Carlos III".

Several works of Anton Rafael Mengs, a German painter known for his frescoes and royal portraits, will be featured. His most famous piece, "Crucifixion of Christ," considered by many to be the most important neoclassical painting in Spain, is traveling to Jackson.

An Italian painter, Giovanni Battista Tiepolo, who painted masterpiece frescos including the ceiling of the throne room in the Royal Palace of Madrid, joins this impressive group of featured artists as do Vicente Lopez, a world-class portraitist and Luis Melendez, regarded as the greatest Spanish still-life painter of the 18th century.

THE OBJECTS

The Royal Gondola of Felipe V, constructed in the 17th century, is the largest and oldest object in the exhibition and hands-down the most difficult to transport. Its intricately carved wood sea nymphs, tritons and sea creatures are currently being restored with \$100,000 worth of gold leaf. The Royal Carriage of Fernando VII, also undergoing restoration for its appearance in Jackson, features gilded bronze, crystal, precious stones and spun silver fringe.

Rare examples of highly ornamental royal furniture from the period will add dimension to the exhibit as will the throne and canopy of Carlos III. Intricately carved ivory sculptures, elaborate firearms of the monarchy, meticulously produced and painted porcelain pieces and 17 extravagantly ornate clocks will make their way across the ocean as will costumes, chandeliers, candelabra and of course, Spanish fans.

THE OPPORTUNITY

Members of the Mississippi State Medical Association will enjoy a sneak preview of The Majesty of Spain Exhibition when the organization joins the Mississippi Hospital Association in hosting the only pre-opening gala for the event on February 27. Two days before the official exhibit opening, MSMA and MHA members will experience one of the nation's premier art events of 2001 along with our guests, state and nationally elected officials whose support enabled this endeavor. The capacity for this reception will be limited, so watch for ticket information in future MSMA communications. Take the bull by the horns and don't miss this unique opportunity.



A compelling figure of a Chinese man overlooks the recreation process of the Porcelain Room from Royal Palace of Aranjuez.

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Seeking Nominations for the 2001 MSMA Award for Community Service

The **Annual Physician Award for Community Service**, sponsored by Mississippi State Medical Association, is designed to provide recognition to members of the association who are actively engaged in the practice of medicine, for the many and varied services above and beyond the call of duty which they render to their respective communities.

Each recipient of the award is nominated by his or her component society and selection is made by the members of the Council on Public Information. The intent of the program is to honor only living persons, and to honor no person more than once. Presentation is made at the annual meeting of the association's House of Delegates. Every society has many members worthy of this distinguished award. It is your society's responsibility to see that they are nominated. All nominations should be submitted to the Mississippi State Medical Association by March 16, 2000.

The award is a handsome plaque which features a cast bronze medallion. The medallion's design symbolizes the close relationship between medicine and the community. A **\$500 contribution** is also made by the association to a civic organization designated by the award recipient.

Nominations should be submitted in writing. There is no particular form required in this regard; however, since the award is for outstanding community service it is important that all accomplishments of the nominee in this regard be presented in detail. The Council on Public Information encourages you to seek the assistance of your local MSMA Alliance in preparing the written nomination and supporting materials.

Nomination supporting documents may include all or some of the following: a narrative about the person and his community involvement, newspaper clippings, letters of support from community leaders, newspaper or magazine articles written about the person, photographs and other materials that show the person's community involvement.

Nominations should be sent to MSMA, P.O. Box 2548, Ridgeland, MS 39158-2548, as soon as possible but no later than March 16, 2000. For further information please contact: Karen Evers, Director of Communications, (601) 853-6733 or 1-800-898-0251.



*The Mississippi State Medical
Association Alliance Board
and
the County Alliances
would like to wish all
Mississippi Physicians blessings
for a joyous holiday seasons.*

<i>Ann Hopper</i>	<i>Jo Waites</i>	<i>Delicia Carey</i>	<i>Karen Entriken</i>
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Season's Greetings

**Thank you to all who contributed to this Holiday Sharing Card.
All proceeds were donated to the AMA Foundation, Inc.**



The Spirit of Giving

Candace E. Keller, M.D., M.P.H.
The President's Page

I will honor Christmas in my heart and try to keep it all the year. I will live in the Past, the Present and the Future. The spirits of all three strive within me. I will not shut out the lessons that they teach.

— Charles Dickens

The Christmas holiday season is always filled with a myriad of activities, memories, and emotions. It is a joyous time in which the spirit of giving seems particularly predominant in most everyone.

I love the hustle and bustle of shopping in search of gifts for family and friends. I especially enjoy the looks of intrigue and glee on the faces of my niece and nephew as they survey the presents all carefully wrapped beneath the tree.

I love all the special scents of the season. There's nothing quite so wonderful as the smell of Mom baking cookies, cakes, and all her other goodies in the kitchen. I like the scent of a freshly cut "real" tree as it permeates the house. And then there's those "chestnuts roasting on an open fire".

I love the sights and sounds of Christmas — the brightly decorated stores and streets adorned with lights and various other holiday symbols. And oh, how the sounds of music lift and fill our hearts!

But to me, the most important and remarkable aspect of Christmas is the unique generosity of the human spirit. After all is said and done, the most memorable gifts are not really the material ones, but rather the demonstrations of love we give to one another. Whether it is a smile, a hug, or the whistle of a happy tune, may we remember and carry that special spirit of giving that comes only from within all through the year.

May you each have a blessed Holiday season and a New Year filled with wonder, discovery, and excitement!

Candace

Mississippi State Medical Association Alliance Will Sell Artist Ray Freeman, M.D.'s Christmas Cards

As a personal favor to Peggy Crawford of Louisville, Dr. Ray Freeman has donated approximately 1,000 of his beautiful Christmas cards to the MSMAA. Dr. Freeman's only stipulation was that all the proceeds go to the AMA Foundation Inc.

Mrs. Crawford met Dr. Ray Freeman, who was a friend of Dr Edsel Stewart of McComb, Mississippi, at a Southern Medical Association meeting. Drs. Stewart and Freeman share the talent of being gifted artists. Dr. Ray Freeman is from Harte Center, Texas, and he exhibits his art work at the Southern Medical Association meetings each year. He donated a previous set of Christmas cards to the AMA-ERF when Mrs. Crawford was the National AMA-ERF Chairman in 1994-1995. Recently he contacted Mrs. Crawford again with a generous donation of a new set of Christmas cards that he has produced.

The MSMAA will be selling Dr. Freeman's cards in packages of 25 for \$20. You may order these lovely cards by sending the bottom portion of this page to Susan Rish, AMA Foundation, Inc. Chairman, P. O. Box 2483, Tupelo, Mississippi 38803. Make your check out to the AMA Foundation and, as always, this is a tax-deductible donation.

Number of Packets of cards:times \$20 = \$ Total

Please mail cards to:

Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ **County:** _____

Editorials

JOURNAL OF THE
MISSISSIPPI STATE MEDICAL ASSOCIATION
VOLUME XLI, NUMBER 12
DECEMBER 2000

BUREAUCRACY IS ONLY SKIN DEEP

Mr. Taylor has the kind of skin that produces actinic keratoses like Smith County grows watermelons. And his countless hours of hatless sun exposure as a highway road hand have served as a time-release fertilizer for a bumper crop in later years.

Through the diligent yet judicious use of my trusty cryo unit, I've been able to weed out these precancerous lesions. In fact, Mr. Taylor delights in bragging that his face is finally as smooth as the proverbial baby's bottom.

The arrival of the letter from "A HCFA Contracted Carrier" denying payment for my services silenced my grateful patient's thanks still ringing in my ears. Despite my prompt reply including the fact that the services of a plastic surgeon had been required in years past to excise multiple basal cell carcinomas as well as severe dysplastic actinic keratoses and that my timely cryo surgery probably saved Medicare megabucks in the long run, my request for reconsideration fell on deaf ears. Included in the denial was the cryptic statement, "There was no documentation to suggest lesions were symptomatic." Say what?

Some six months later (I had actually forgotten the matter), a three-page single-spaced typewritten epistle (containing headings such as SERVICES AND ISSUES, FACTS, DECISION, RATIONALE, APPEAL RIGHTS) was received from the "Medicare Hearing Officer" affirming the prior determination. Payment for destruction of ten facial actinic keratoses during a single office visit was denied on the grounds the services exceeded "Medicare frequency guidelines." I suppose that I had "zotted" the areas in too rapid succession!

Further, I was informed that a patient's medical record must contain a written description of each lesion "in terms of its location and physical characteristics." "Signs and symptoms noted by the patient" must also be recorded. By the time these criteria were met, I could probably have seen another three patients (or at least signed another six more Medicare forms!).

Rest assured that our congressional delegation will receive a copy of this bureaucratic boondoggle. However, painfully aware that politicians will see this as a pocketbook issue rather than a quality of care issue, I know that we must enlist the voices of our patients in our protest if common sense is to prevail.

— *Stanley Hartness, M.D.*
Associate Editor

The editorial opinions expressed in this Journal are those of the indicated author. Editorial opinions are not expressions of the views, or official policies of The Mississippi State Medical Association. We encourage the membership to submit letters for publication regarding any opinion expressed or information contained in the Journal MSMA.

World Medical Masses Still Flock to “Get a Guyton”

A textbook that taught physiology to medical students around the world for 45 years is being released in its 10th edition.

The Textbook of Medical Physiology is the life's work of Dr. Arthur Guyton. Although officially retired as chairman of the Department of Physiology and Biophysics at the University of Mississippi Medical Center in Jackson, the 81-year-old Guyton still comes to the department daily and constantly updates his book.

In sales, his volume "dominates" all other medical textbooks, according to William R. Schmitt, editor-in-chief of medical textbooks at Harcourt Health Sciences, which is Guyton's publisher.

"I don't know if we can say it's the best selling medical textbook ever, but it certainly is the world's best selling physiology text," he said.

Guyton is one of the preeminent cardiovascular physiologists in the world. Most of what is known about heart function and blood pressure comes from data gleaned from research in his department at the Mississippi medical center.

The textbook is published in or being translated into 15 foreign languages.

A new marketing slogan used by Harcourt — "Gotta Get a Guyton!" — appears on posters in medical school bookstores, on neon yellow pens and on promotional T-shirts. It's a phrase medical students have heard for decades, said Guyton's co-author, Dr. John Hall.

"Medical students hear it from other medical students: 'If you want to understand this stuff, you've gotta get Guyton's book.' Hall, Guyton's successor as department chairman, contributed to the new edition.

Guyton, a modest scientist by any standards, hesitates to speculate about why the book is so popular. "We've tried to write it in the language of medical and research students. I hope we have succeeded," he said.

Asked whether he had a clue that his initial book would become a classic, Guyton only said, "It became so useful that writing it had to take priority.

"It has been my great privilege to work with Dr. Guyton on the ninth and 10th editions, but he is the sole author of the first eight editions," said Hall, who came to the Mississippi medical center in 1974 as a postdoctoral fellow to study with Guyton.

In 1996, Guyton, now professor emeritus of physiology, received the Association of American Medical Colleges' Abraham Flexner Award specifically for the influence of his book on medical education in America. His countless honors include every major award in cardiovascular physiology.

Research in Guyton's medical center department, now directed by Hall, has been funded continuously by the National Institutes of Health (NIH) since 1968. It may be the longest-running grant in NIH history.

Over the years, the Guyton book also has attracted a tremendous following among veterinary students for the same reasons medical students prefer it.

Dr. David Jennings, professor of veterinary medicine at Mississippi State University, has taught physiology for 30 years and knows the book well. "Some of the texts written specifically for veterinary physiology are more superficial, with not as much depth in areas such as cell biology, and they are not written in prose a student can understand. Guyton's book has filled a real need for a lot of students in teaching basic principles of physiology," he said.

Unique among other medical textbooks for its sales — Hall estimates that the book sells from 140,000 to 150,000 copies per edition — the book is also a rarity for its single authorship. Until the ninth edition, it was the sole work of Guyton, who makes continuous updates based on cardiovascular research in his own department.

and by prodigious reading of other aspects of physiology.

Until his retirement as department chairman in 1989, his practice was to dictate the text at night at home, and bring the tape to his office for his secretary to type. His secretary, the late Billie Howard, has said she often heard the sounds of children playing in the background when she transcribed the tapes.

Guyton and his wife have 10 children, all of whom are physicians. Guyton said paying medical tuition 10 times was a big motivator of his continuous authorship.

The book, first published in 1956, began as lecture notes when he was teaching physiology to medical students in the early 1950s at the University of Mississippi in Oxford, a few years before the medical school moved to Jackson and expanded. He discovered that his students had trouble with the textbooks available, so he began copying and passing out his lecture notes.

"It still has that tone to it — a teacher talking to his students," Schmitt said.

Schmitt, who is accustomed to dealing with medical writers, says he has learned not to worry about getting Guyton's manuscript on time. "Sometimes I will panic, because I remember that it's been a while since the last edition, and I'll call Dr. Guyton to tell him it's about time for another edition. He will have been making revisions since the last edition, and he always says he can send it whenever we want it," he said.

The book is simply a major contribution among many in a long career devoted to science and education.

Guyton's legacy — the fundamental discoveries about the cardiovascular system, the textbook (and 600 other publications) and his family — has flourished from the confines of a wheelchair. As a promising surgical intern at Massachusetts General Hospital, he contracted polio in 1946.

After a period of recovery, Guyton faced the realization that the residual paralysis would derail his plans for a career in cardiovascular surgery. He turned instead to his other consuming intellectual interests, research and teaching. Medical students around the world are grateful for that career choice.

Dr. Jean Pierre Montani, chairman of the Department of Physiology at the University of Fribourg, Switzerland, first studied Guyton's textbook as a medical student there decades ago. After graduation and before returning to Switzerland, Montani spent 13 years in Mississippi in Guyton's department, first as research associate and finally as associate professor.

"I've always appreciated Dr. Guyton's approach to physiology — studying the entire system as a whole

instead of little parts," Montani said.

Medical students who study physiology at Fribourg always have access to five copies of the current edition of Guyton's text, which Montani keeps on reserve in the departmental library.

"Guyton's concepts are mentioned quite frequently in any physiology course in Switzerland, and all of those concepts are described very eloquently in his textbook,"

UMC's Vance Tracks True Impact of Chemo Drug



Ralph B. Vance, M.D.

Dr. Ralph Vance presented the largest study of its kind at the ninth World Conference on Lung Cancer last month in Tokyo.

For three years, the Jackson oncologist and University of Mississippi Medical Center professor of medicine coordinated the prospective study to track the efficacy of the widely used chemotherapy drug paclitaxel (Taxol).

Vance's study followed 53 patients at 29 U.S. medical centers who received paclitaxel in lengthy, 96-hour infusions. Infusions were given from three to six times, as needed, over several months.

Paclitaxel is used in chemotherapy for non-small-cell carcinoma. The targeted cancer in this study was bronchioloalveolar carcinoma (BAC). BAC is suffered by nearly one-fifth of lung cancer patients. It's difficult to diagnose because it may mimic infections in the lung, Vance noted.

All patients in the study had an advanced stage of inoperable BAC, stage IIIb or IV.

"This is the only lung cancer not associated with smoking — and this type (BAC) is on the rise over the past 30 years," Vance said. "We don't know why it's increasing."

Even though the drug's effect on patients in the study was "minimal," the results are somewhat "encouraging," Vance said.

"Twelve percent of the 53 patients did get a partial

response, meaning their cancer showed some evidence of receding," he said. Cancer stabilized, or had no change, in another 38 percent. But 29 percent of patients suffered increasing disease, study results show.

"We think of a drug as 'active' if it changes the course of a disease in 20 percent of patients. So this one is minimally active at only 12 percent," he explained. But the 38 percent stable rate could be a positive indicator.

No other chemotherapy drug has been proven to be "active" in the treatment of BAC in any prospective trial, he noted.

Vance said paclitaxel has proven to be far from a magic bullet. But, since BAC is such a difficult cancer to treat, there are few good treatment options if the patient is not operable. Since the response rate was above 10 percent, paclitaxel might have a more positive effect if used in combination with other chemotherapy drugs, he said.

In addition to the University of Mississippi Medical Center, the 29 institutions that participated in the study included the medical centers at the Universities of California at Los Angeles, Columbia, Temple, St. Louis and Kansas as well as the City of Hope in Duarte, Calif., and Scott & White in Temple, Texas.

The study was funded by a grant from the National Cancer Institute through the Southwest Oncology Group.

UMC's One-of-a-kind Winfred L. Wiser Hospital for Women & Infants Celebrates First Birthday

The "One and Only Celebration" marked the birthday of the Winfred L. Wiser Hospital for Women & Infants with a party recently.

Mississippi's one-year-old and only comprehensive hospital for women and infants has enjoyed a healthy beginning.

Since its October 1999 opening at the University of Mississippi Medical Center, Wiser Hospital for Women & Infants had an 81 percent occupancy rate and delivered more than 3,700 babies. Its newborn nursery had an average daily census of 27 for 34 beds. In the neonatal intensive care unit (NICU), the average daily census was 100 percent for 64 beds; actual capacity in the unit is 96 for future growth.

"It's been wonderful seeing the pleasure of the patients. They've had such a positive response to the state-of-the art facility and its technology," said Diane Dukes, Wiser director of nursing services. "It's also been so uplifting to our staff, offering top-quality service in a top-quality facility."

The "One and Only Celebration" culminated with a birthday party for the public and UMC faculty and staff.

Mitchell Ends Term as Leader of 4,200 Member Allergy Group



Don Q. Mitchell, M.D.

The outgoing president of the American College of Allergy, Asthma and Immunology (ACAAI) is a Jackson allergist and clinical professor of medicine at the University of Mississippi Medical Center (UMC).

Dr. Don Q. Mitchell, who practices with the Mississippi Asthma and Allergy Clinic, ended his term as president of the national professional group during the annual meeting in Seattle November 3-8.

"It's been a wonderful year," Mitchell said. "We've been to Australia, Portugal and nearly every state in the country. They know me well at Delta Airlines."

Department of Medicine chairman Dr. Rick deShazo, who is also an allergist and immunologist, says election to the presidency of this organization "is a very unique honor afforded very few people. It brings a tremendous amount of recognition to this state and to this medical school. We're all very proud of Don."

"I've always felt very close to the Medical Center. It's where I learned by livelihood," Mitchell said.

He is a past president of the Medical Alumn

Chapter of the University of Mississippi Alumni Association and for years, until the Medical Center had full-time allergists on staff, ran the allergy clinic at UMC with Dr. Faser Triplett and Dr. Ellis Moffitt.

Mitchell is also working with deShazo on finding funding for an allergy-immunology fellowship at UMC.

"Twenty percent of all Mississippians have allergies, and we don't have a training program yet," deShazo said.

Mitchell has volunteered his clinic as the training site for fellows. "The vast majority of allergy and asthma patients are treated in outpatient settings, so this will be great as a training site."

Mitchell, a native of Cleveland, is a Millsaps graduate and is past president of its alumni association. He currently serves on the Millsaps Board of Trustees. He graduated from medical school at UMC in 1967, did a rotating internship at UMC, then completed a residency and fellowship in allergy and immunology in the Air Force.

"I spent nine years on North State Street in Jackson and couldn't wait to get back," he said. His clinic is at 1600 North State Street.

In addition to his current post as president of the ACAAI, Mitchell has been a delegate to the American Medical Association since 1993, served as president of the Mississippi State Medical Association, president of

the Central Medical Society and two terms on the board of governors of the American Association of Certified Allergists.

As if he didn't keep busy enough with organized medicine and an active practice, Mitchell is also a prolific researcher. "Research really keeps us on the leading edge. If a new drug comes along, we've usually been involved in the research on it or in the process of working with it," Mitchell said.

This year, Eboni Mikelle Smith, a first-year medical student, holds the Don Q. Mitchell, M.D., Scholarship, named for Mitchell. Two other African-American medical students at UMC hold scholarships named for other physicians who are related to Jim and Sally Barksdale. The Barksdales established the "full-ticket" scholarships, at the urging of Mitchell, to assist the medical school in attracting and keeping highly qualified minority students.

"Don has meant so much to this medical school and to the Medical Center," said UMC vice chancellor Dr. Wallace Conerly. "He has worked tirelessly with our students and residents to provide allergy training. His leadership through the alumni functions has set an example for all of us, and his successful recruitment of the Barksdale support for African-American scholarships is truly a lasting legacy. This institution will be forever indebted to him for what he has done."

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Personals

Jeff Clark, M.D. has been named Chief of Staff at King's Daughters Medical Center in Brookhaven for the 2000-2001 year. Dr. Braxter Irby was the outgoing Chief of Staff.

Burton Friedman, M.D. recently received a plaque from Dr. Bob Gannaway, chief of staff at Hardy-Wilson Hospital in Hazlehurst, recognizing his 50 years of medical practice in Copiah County.

Will Sorey, M.D., an assistant professor of pediatrics at the University of Mississippi Medical Center, recently served as adolescent medical consultant of Strong Bows and Straight Arrows, a Jackson Area Parents' Council (JAPC) parenting handbook.

Paul H. Moore, Jr., MD, of Pascagoula, has been named as a fellow of the American College of Radiology (ACR). The announcement was made during the ACR annual meeting held in New York, New York.

Selected for outstanding contributions to the field of radiology, Dr. Dr. Moore was named as one of 96 new fellows by the College's Board of Chancellors.

Fellowships in the College are awarded to members for significant scientific or clinical research in the field of radiology or significant contributions to its literature. Criteria for selection also include performance of outstanding service as a teacher of radiology, service to organized medicine and an outstanding reputation among colleagues and the local community as a result of long-term superior service.

ACR is a national organization serving some 32,000 radiologists, radiation oncologists and medical physicists, with programs focusing on the practice of radiology and the delivery of comprehensive radiological health services.

Roberta Chilimigras, MD, a family medicine physician, was elected vice president and internal medicine physician **James Crittenden, MD**, was named secretary of the medical staff of Hancock Medical Center recently for the 2000-2001 term. Members-at-large are family medicine physician **Sidney Chevis, MD**, family medicine physician **Bertin Chevis, MD**, and urologist **Thad Carter, MD**. **Keith G. Goodfellow, M.D.** retains a seat as past chief.

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Wand of Aesculapius

Looking Back: Prostatectomy

Selected and edited by Lucius Lampton, MD, Associate Editor

[This month, we look back to a report published in the Transactions of the Mississippi State Medical Association, which was presented at the Forty-seventh Annual Session, held at Columbus on April 14-16, 1914. It was written by widely admired physician Dr. John Darrington, M. D., of Yazoo City. Darrington, a native Mississippian, was born in 1870. After getting his undergraduate degree at Mississippi State (then A. & M.), he studied medicine at Tulane, graduating with an M. D. in 1892. He interned at Charity Hospital in Natchez and practiced several years at Eden. He then took post-graduate studies in New York and returned in 1898 to establish Yazoo Hospital, a private hospital in Yazoo City. He was a

member of the State Board of Health for several terms. He also served as president of the MSMA from 1927-28. Upon his death in 1947, Dr. Felix Underwood commented, "I believe every doctor in Mississippi knew "Dr. John," and those of us who were privileged to know him well and to have his friendship loved and respected him. I am afraid it will be a long time before we see his like again. During his service on the Mississippi State Board of Health, 1907-1915, and again 1929-1935, he was an inspiration to me and to every member of the Board." He was known for his surgical skills, and we look back to his comments on prostate surgery.]—Ed.

There are two reasons why hypertrophy of the prostate gland should be of unusual interest to every man present. In the first place, it is a trouble that you frequently meet in practice, and in the second place, you must remember that one in every four of you who live to be sixty years of age, will have a chronic hypertrophy of your prostate.

The pathology of prostatic enlargement must be thoroughly understood if we expect to give the individual case the very best advice, and if an operation is indicated, a clear understanding of the nature of the enlargement will be of the greatest aid in selecting the type of operation best suited to the case in hand, and the one that will not only give us the lowest mortality, but also the least morbidity.

We know, for instance, that in the glandular hypertrophy we have a large comparatively soft fibro-adenomatous tumor that is well encapsulated, and easily enucleated, while in the fibrous type the gland is much smaller, more difficult to reach, and cannot be shelled out because it is not encapsulated. The chronic inflammation that is so often associated with enlargement of the prostate, also makes it more difficult to enucleate.

The clinical symptoms by no means depend on the size of the gland, for an enormously enlarged prostate may not cause any obstruction, while a very small gland, by its intra-urethral or intra-vesical enlargement, may completely block the urinary passage, and it is in this class of cases that the cystoscopic examination furnishes accurate information regarding the small prostatic projections. The value of this instrument, unfortunately, only comes from wide experience and, even in expert hands, its use is frequently unsatisfactory or impossible, on account of inflammation, haemorrhage or obstruction.

The symptoms usually develop slowly, run an irregular course without special complications until complete retention of urine occurs. It is unfortunate that most cases are willing to wait until complete obstruction before giving their consent for surgical relief, for it is this delay that results in damage to the cardio-renal system, and I wish to impress you with the fact that a keen appreciation of the maximum capacity of these organs is the key to success in prostatic surgery.

An accurate estimation of the capacity of the heart and kidney to withstand an anesthesia and operation is of the utmost importance, therefore, the *preoperative* treatment is really of more importance than the operation. Place

these cases in bed, use a constant drainage catheter with frequent irrigations; give large quantities of water with some urinary antiseptic, clear out the bowels thoroughly, and measure the urine passed each day, and when the quantity and quality of urine is normal, the operation can be done with a considerable degree of confidence in the patient's recovery.

When we are ready for the operation, the question to decide is what route shall we select. When I hear a surgeon advocating either the perineal method exclusively, or the suprapubic route in all cases, I am inclined to think that his success with that special operation has interfered with his appreciation of the merits that each route possesses, for there is no doubt that each has its place in the safe and satisfactory removal of the gland.

For many years the perineal operation was the most frequently performed, but since the meeting of the International Congress of Urology in London in 1911, the tendency has been to regard with more favor the suprapubic route.

The perineal operation however, is clearly indicated in malignancy, tuberculosis, small rigid bladder, extremely fat patients, and in all cases of scirrus enlargement, because the gland is not encapsulated, and therefore cannot be enucleated.

In all other varieties of prostatic enlargement the supra-pubic route is preferable for the following reasons:

1. The mortality is no higher.
2. The complete removal more certain.
3. Fistulae are less frequent.
4. Drainage is better.
5. Sepsis rare.
6. Small loss of blood.
7. Stone removal easy.
8. Incontinence less frequent.
9. Operation simple.
10. Permanent results are better.
11. After treatment, more agreeable to the patient and doctor.

In connection with this operation, it is well to remember the following points:

1. Careful preoperative preparation of your patient.
2. Use nitrous oxide-oxygen anesthesia, if possible.
3. Incise rather than tear through the fat which leaves a single space to drain.
4. Use a very large drainage tube.
5. No sutures through bladder wall.
6. No instruments or catheter to be introduced through urethra after operation unless obstructive symptoms occur.

The supra-pubic and perineal operations are the only two that we need consider for such operations, as Bottini's electrocautery method has long been abandoned, and the only operative treatment now in vogue, short of complete removal, is a plan being used by Dr. Young, who has ingeniously devised an instrument which he terms a "urethrosopic median bar incisor" or "punch" with which he is able to excise the median portion of the prostate by introducing the instrument through the urethra. I doubt that this instrument will ever become popular in less skilled hands, and with the average operator, "tinkering" with an enlarged prostate is certainly an exhibition of poor judgment.

Considering the fact that prostatic enlargement usually comes with advancing years, and at a time when there has occurred degenerative changes in the vital organs, the conscientious surgeon must therefore approach these cases with considerable anxiety. I am convinced, however, that a careful study of the case, a careful preparation of your patient, a suitable and quick operation, with equally as attentive and faithful after treatment, will certainly amply repay you by more prompt recoveries, and by greatly reduced mortality.

— John Darrington, M. D., Yazoo City
Transactions of the MSMA, 1914, pages 110-115

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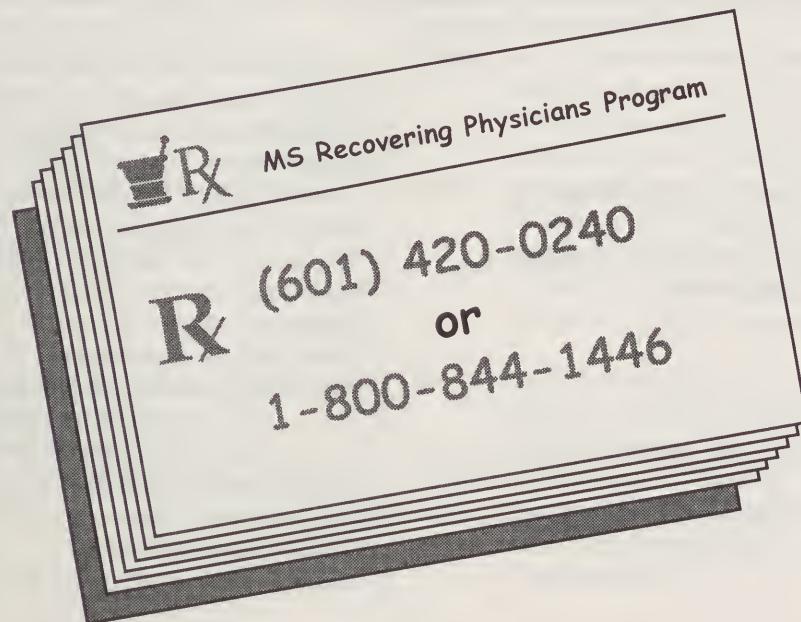
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